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ORIGINAL LECTURES.

CLINICAL LECTURE

ON CASES ILLUSTRATING THE USE OF ADONIDINE IN DILATED HEART, AND THE TREATMENT OF CEREBRAL APOPLEXY.

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GENTLEMEN,—I shall bring before you cases, this morning, which will serve to illustrate some therapeutical points which you may find to have practical value. The first one is the case of A. B., a man, 23 years of age, in whose family history we can trace rheumatism, and whose occupation constantly exposes him to changes of weather: he is a teamster. Previous to his present malady he states that he enjoyed excellent health. He has never had rheumatism, and denies specific infection. There is no evidence of excesses in drink, he smokes moderately, and, in truth, his habits in every respect appear to be good. Up to the time of the onset of his present illness he does not recall the fact that he had been at all troubled with shortness of breath. About three months prior to his admission into the hospital, which was on the 29th of November, he noticed that he had diarrhoea and paroxysmal pains in the lower part of the stomach, and also pain in his chest, accompanied by difficulty in breathing. Indeed, this dyspnoea at once assumed serious proportions, and it has continued ever since,—according to the notes, at times more, at times less, severe; but there seems to be no time, either in the day or night, in which he did not suffer with shortness of breathing. About three weeks prior to entering the wards he also noticed palpitation of the heart, coming on irregularly, which increased his discomfort. He had no attacks of vomiting, and his digestion was good. He continued at his occupation until the middle of November, when he was obliged to give up heavy work, and confined himself to light labor about the stable. On the 20th of November his feet began to swell, and the swelling

steadily increased; it was not accompanied by oedema in other portions of his body. Prior to admission there was another outbreak of diarrhoea, but it was unaccompanied by marked gastric symptoms.

His condition on the day of admission (November 29) was entered upon the notes as follows. "Face puffy, feet and legs greatly oedematous; his lips and nails cyanotic; his pulse weak and irregular. The urine was scanty, of specific gravity 1024, and contained a small proportion of albumen, but no tube-casts were detected." The axillary temperature was sub-normal: the record states that it was 98° on admission; for the next eleven days, as you see by the chart, it remains about 96°, occasionally rising to 97°. On December 11 it becomes normal, and remains subsequently at 98.4°.

Now, gentlemen, irrespective of what I have told you, we have here a note of a heart-examination made the day subsequent to admission which shows what is the source of this man's illness. "Heart's action is extremely irregular; percussion-dulness extends almost to the right edge of the sternum from a point outside the mammary line; the apex-impulse can be felt in two intercostal spaces, and in this region there is present a distinct presystolic murmur. The second sound of the heart is heard at the base, and is especially distinct at the left base."

The diagnosis was made of mitral organic lesion, with narrowing of the orifice, stenosis. At the same time the increased percussion-dulness and the extended impulse, the apex-beat being feeble as compared with the extent of the dulness, give us a further diagnosis of cardiac dilatation with slight hypertrophy. The pulse was feeble, irregular, and difficult to count, but was about eighty in the minute. This is the record of the heart-lesion. The lungs presented nothing of importance.

We placed the man upon digitalis, with, to a certain extent, good results. Under the infusion of digitalis this happened: the dropsy disappeared, and the breathing was somewhat relieved; the heart's action became more regular and increased in force, but not to the extent that we hoped. Indeed, the action of the digitalis seemed here to be chiefly diuretic, and expended on the dropsy: it was very slight upon the heart.

After waiting several days I concluded that a pure heart-tonic would be serviceable, and then gave him the new remedy, adonidine: one-tenth of a grain was given three times a day at first; subsequently it was given five or six times in the twenty-four hours. The effect of this upon the heart was strikingly good.

In the first place, from the dates I see clearly that the temperature rose coincidentally with the administration of the adonidine; the low temperature, which had continued all the time he was taking digitalis, ceased when he began to take the new remedy. Secondly, this was attended with an increase in the strength and action of the heart, proving its influence as a cardiac tonic. In one respect adonidine was different in its action from digitalis: it had no diuretic action. The urine came down to a pint in twenty-four hours; and this made me, on the 24th, return to the digitalis (a dessertspoonful of the infusion four times a day); the urine at once increased, but the improvement in the heart remained stationary.

Having told you his clinical history, I will now examine him before you. With regard to his shortness of breath, this is vastly better. This was noticed at first under digitalis, but the greatest improvement occurred when he was taking adonidine. His face is somewhat suffused and the capillaries are enlarged, but not nearly to the extent that they were at first. The dulness on percussion in the cardiac region is large, the apex beats to the left of the nipple, and the impulse has more force than it had, but it is still more diffuse than it should be. There can be no doubt that the heart's impulse is stronger than it was. Auscultation reveals, just over the apex, a most marked presystolic murmur, passing over into the systole. In other words, there is narrowing or stenosis passing into insufficiency. With regard to the second sound, I find it accentuated, but the difference between the right and left base is not very marked, not enough, at least, to make it a point in the diagnosis. The murmur is also heard, though faintly, at the angle of the left scapula. There are no marked pulmonary signs.

This case is diagnostically clear enough. I did not purpose discussing the points of diagnosis with you; it is the therapeutic aspect of the case which is so striking, as it enables us to draw some comparison be-

tween digitalis and the new alkaloid, adonidine. I selected this agent because, while its powers as a heart-tonic are not inferior to digitalis, it is free from the disturbing action of the latter. There are so many claims made in favor of new drugs, and especially heart-tonics, that it makes one suspicious of them all; but having used adonidine for some time, I consider it a valuable addition to our therapeutics of heart-affections, and have not observed from it anything resembling the cumulative effect which at times, though rarely, follows the administration of digitalis. In this case the contractions of the heart, while they became more regular, were reduced to fifty-six per minute. He had slight vertigo and headache, which disappeared upon resuming the infusion of digitalis, while the adonidine was continued. This drug will never supersede digitalis in the treatment of cardiac dropsy, from its want of diuretic action, but in other cases this might prove a decided advantage. Without discussing the effects of the agent upon the cardiac dilatation and hypertrophy, and merely referring you to the relief from the dyspnoea and the increase in the strength of the pulse, I point out to you that all this was associated with a very considerable amount of cardiac dilatation or stretching, with very little hypertrophy. There is another patient in the ward with very decided hypertrophy in whom the adonidine produced disagreeable results: the heart's action became intensified, and attacks of palpitation came on upon slight exertion. I recall another case in private practice where the same result occurred: the heart was strengthened too much. This all shows that it is a decided heart-tonic, and also indicates its line of usefulness. In a given case of weak and disordered circulation, the nearer it approaches a condition of dilated heart the more benefit from the adonidine; the more it approximates hypertrophy and overaction of the heart, the more is this agent contra-indicated. In cases of weak digestion with weak heart, it is especially suitable.

CEREBRAL APOPLEXY — HEMIPLEGIA — PROMPT TREATMENT BY VENESECTION — RECOVERY.

In conclusion, I will ask your attention to a case which you have seen in its more acute stage. This was a case of apoplexy with left hemiplegia. The man has done

very well, but I thought that it might be of interest to you to observe the effects of treatment. When admitted, twenty ounces of blood were taken from his arm with evident benefit, and croton oil was given, which purged him freely. One drop of tincture of aconite was given every second hour at first; four days later he was given potassium iodide, a scruple four times daily.

You see that this man has recovered power to a very considerable degree, and the leg is regaining strength even more than the arm. Some facial paralysis remains. He has now reached the stage for local treatment, massage, friction, and stimulation of the muscles by the use of mild faradic currents.

It is always a nice question when to begin this local treatment after apoplexy. My rule is to begin rather late than early. I wait until voluntary power commences to return in the muscles. If it is begun too early we run the risk of increasing the brain-lesion. Later still, I usually give strychnine. I believe that harm is done by using either too early.

This patient has reached a stage in his history when the brain-malady is not active, and we will therefore use massage daily and electricity every second day.

There is still a trace of albumen in the urine. In every other respect he has strikingly improved. You remember that I told you, when he was the subject of discussion before, that the albumen in the urine had something to do with causing the hemiplegia: therefore its persistence now simply proves that the original view was correct.

ORIGINAL COMMUNICATIONS.

REPORT ON THE PROGRESS OF DERMATOLOGY.

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(Continued from page 539.)

THE SYPHILODERMATA.

TWO papers have recently appeared upon hemorrhagic syphilis. In the first of these Horovitz (*Vierteljahresschr. f. Derm. u. Syph.*, Jahrg. xiii. S. 351) gives an account of two interesting cases observed in Auspitz's clinic. The first was a man, of 26, suffering from an early generalized syphilo-

derm of the papular variety, which was cured by mercuric inunction. He was then placed upon twenty-four grains of potassium iodide thrice daily, but within ten days an eruption of small red papules occurred upon the body and limbs which soon took on a hemorrhagic character. The potassium iodide was then suspended, but new lesions continued to come out for about twelve days.

Horovitz's second case was a young man, of 25, in the early stage of generalized syphilis, showing moist papules about the arms, etc., who also displayed a peculiar eruption chiefly upon the forehead, back, and extremities, excepting the hands and the feet. This eruption was composed of confluent lesions: in the centre of each a large flat papular lesion, and around this a hemorrhagic ring, the whole compound lesion in some places being as large as the palm of the hand. The patient was placed under observation without treatment, and the eruption gradually disappeared, being practically gone at the end of six weeks.

Horovitz theorizes at some length over these cases, but the first seems very much like an iodide-of-potassium eruption, while the last is worthy of attention whether the hemorrhage was due to syphilis or not.

Hartmann and Pignot (*Annales de Dermatologie et de Syphiligraphie*, 2me sér., t. viii. p. 1) put forth a paper on the same subject, but of a very different character, the whole matter being classified and treated under various heads, with illustrative cases. The authors conclude that in congenital syphilis there seems at times to be a true hemorrhagic diathesis. In acquired syphilis there is no proof of a diathetic influence producing hemorrhage from simple wounds. Even when the knife is used upon syphilitic lesions, serious hemorrhage is exceptional. Syphilitic ulcers do not bleed profusely, except where vessels may be laid open by the disease-process. Syphilis may, however, cause arteritis, and thus lead to softening of the walls of the blood-vessels, particularly those of the brain. Paroxysmal hæmoglobinuria is not unfrequently caused by syphilis, operating, as Murri thinks, both on the organs which form the globules and on the vaso-motor centres. Syphilis may give rise to cutaneous hemorrhages, (a) on the surface of pre-existing lesions, (b) by acting as a determinate cause of a purpura which shows itself in the secondary stage of the disease,

and with the usual symptoms of that affection.

Weyl, in his article on psoriasis in Ziemssen's Hand-Book, having asserted that syphilis has no influence upon psoriasis, Dorwig (*Vierteljahresschr. f. Derm. u. Syph.*, Bd. xiii. S. 149) asks the converse question, Has psoriasis any influence upon syphilis?—*i.e.*, as regards the development of the syphilodermata,—and believes himself in a position to answer the question in the affirmative as the result of his observation of a case of which he gives the notes. A young man came under his care suffering from an initial lesion of syphilis, who also displayed an extensive and well-marked eruption of psoriasis which he had had for eight years. When the generalized syphilitic eruption broke out, which took place with headache, fever, etc., about two weeks after he came under Weyl's observation, it was found that the syphilitic eruption had at many points supplanted the psoriatic lesions, the transformation taking place gradually and *in situ*.

Weyl contrasts the pathological anatomy of the psoriatic and syphilitic eruptions, and demonstrates how the peculiar enlargement and multiplication of the capillary loops in psoriasis favor the development of the syphilitic lesions. His views appear very plausible, and are worthy of further attention.

It is known that syphilis does not preclude the synchronous occurrence of the acute infectious diseases. These, however, suppress the appearance of syphilitic symptoms temporarily, but the latter return when the intercurrent acute infectious disease has run its course. An exception to this fact has, however, been asserted in the case of erysipelas, which is said to have a certain curative influence on syphilis.

Mauriac observed a number of cases of initial lesion and generalized symptoms yield to an attack of erysipelas, sometimes eventuating in a cure, but in cachectic cases unfortunately leading to a fatal termination. Deahna observed a case in which an attack of erysipelas removed the syphilitic symptoms, which returned in a milder form, to be entirely dissipated by a second attack. Other observers have noted similar cases, the erysipelas in some instances affecting only the syphilitic lesions lying in its path, in other instances affecting even distant lesions.

The question has arisen in connection with this subject, whether by weakening the intensity of erysipelas by appropriate cultures an efficient specific against syphilis would be obtained. Unfortunately for this theory, eruptions of lupus and non-syphilitic tumors have also disappeared during attacks of erysipelas, thus throwing doubt upon the specific effect of the erysipelas coccus upon the syphilitic element.

Moreover, occasionally the favorable effect of erysipelas upon such growths is offset by fatal results: *e.g.*, Jarnhe and Neisser inoculated a carcinomatous subject with erysipelas with a fatal result from the erysipelatos process itself.

Schuster gives three cases of simultaneously occurring syphilis and erysipelas which are quite interesting. One was that of a patient suffering from nasal syphilis, where erysipelas originated in a specific excoriation about the ala nasi, spread over the face and scalp, and ended fatally. The second was an old syphilitic patient, who had a similar excoriation about the ala nasi, and who while under treatment was attacked by very severe erysipelas starting from this point, which eventuated in recovery. Two years later, however, marked serpiginous syphilitic ulcers developed. The third case was a patient not suspected of syphilis, who had repeated mysterious attacks of facial erysipelas. The starting-point of these was discovered to be in certain old neglected or unseen syphilitic lesions of the nasal opening. These facts, Schuster thinks, prove erysipelas to differ in no way from the other acute infectious diseases in its influence upon syphilis.

Köbner (*Vierteljahresschr. f. Derm. u. Syph.*, Jahrg. xiii. S. 831) has something to say about the desirability of uniformity in recording cases of syphilis, and gives a scheme for setting down the history and various symptoms of cases of acquired syphilis and also the history and symptoms of cases of hereditary syphilis. The scheme might well be carried out with advantage, and deserves study by younger men because it shows the points of importance in the study of cases of syphilis.

The contributions to the study of syphilitic disease of the skin contained in our American special journal are not numerous. In fact, a single paper by Knoche on a case of "*rupia syphilitica*" confined almost exclusively to one side of the body,

the title of which explains its scope, is all that we have on the subject.

COMEDO.

Two articles on this affection have appeared this year, both in *Morrow's Journal*, and both by Dr. Ohmann-Dumesnil (*Jour. Cut. and Ven. Dis.*, February and July, 1886), who calls attention to what he calls double comedo, where pressure on the skin forces a plug of sebum discolored at each end out of either of two contiguous openings. The circumstance seems to be of little importance.

HERPES ZOSTER: ITS RELATIONS WITH H. FACIALIS AND H. GENITALIS.

Epstein, of Neisser's clinic in Breslau (*Vierteljahresschr. f. Derm. u. Syph.*, Jahrg. xiii. S. 777), says that the question of the identity of these various forms of herpes was raised by Bärensprung in his classical article on zoster years ago. Gerhardt supported this view, and suggested an examination into the relation between the facial herpes of acute febrile diseases and the rise in temperature. Just as there is usually a prodromal neuralgia in zoster, so in facial herpes an initial chill precedes the eruption by three days on an average. The initial chill seems to suggest the probable origin of the eruption; but to explain how the rise in temperature can exert a direct influence upon the minute twigs of the trigeminal, Gerhardt suggests that the nerve passes through a narrow bony canal along with a small artery, which is first narrowed and then enlarged by the febrile influence. The pressure of the nerve-trunk between this artery and the bony wall causes more or less irritation of the nerve-trunk.

In the case of herpes genitalis, Mauriac has been brought to the conclusion that this also is due to a nerve-lesion and is closely connected with herpes zoster. Epstein examines carefully into the *pros* and *cons* of the question, and analyzes carefully the views of prominent writers on the subject, finally leaning strongly to the conclusion that all the forms of herpes have a common pathological origin, however differing in their clinical appearance and course.

DYSIDROSIS.

George Thomas Jackson (*Jour. Cut. and Ven. Dis.*, January, 1886) a case, with chromo-lithograph, of this curious

affection. The eruption affected the face, presenting the usual symptoms of large and small sago-grains scattered over the affected parts, and consisting of freely-distended vesicles with clear contents. The largest vesicles were about the size of a split French pea, the smaller ones were about the size of a pin's head. They were generally discrete, though here and there closely crowded together. When pinched, a clear fluid, with acid reaction, escaped from them. They did not rupture of themselves, and their cover offered considerable resistance to the lancet. The skin otherwise is perfectly normal and free from any appearance of inflammation. The only subjective symptom was a slight itching at times.

The diagnosis lay between eczema, herpes, sudamina, and dysidrosis, and this is carefully worked out by Jackson, who also gives a general account of the disease. He prefers the name "pompholyx," suggested by Robinson, but does not suggest any form of treatment.

PEMPHIGUS.

Sabin (*Jour. Cut. and Ven. Dis.*, 1886, p. 172) gives a case of "pemphigus followed by albuminuria," of which it may briefly be said that it was *not* a case of pemphigus, and that it was *not* followed by albuminuria. The case seems to have been one of the peculiar affection called by Bulkley "herpes gestationis," and by Duhring and other writers considered a form of dermatitis herpetiformis. The patient, a woman, suffered with brief attacks of a bullar eruption occurring in connection with three successive gestations. Six years after the last attack the patient died of Bright's disease, but no relationship between this and the skin-affection is shown.

In marked contrast to Sabin's paper is the thorough and complete study of "pemphigus vegetans (framboesoides)" given by Neumann in the *Vierteljahresschr. f. Derm. u. Syph.*, Jahrg. xii. S. 157.

The affection is that formerly known as "framboesia syphilitica," "mycosis syphilitica," etc., two chromo-lithographs of which are given in Kaposi's atlas under the name of "syphilis cutanea papillomatosa." It is not, however, syphilitic in its nature, and should be carefully differentiated from syphilis. The disease presents the following features. A few linseed-sized blebs appear, which at first are

flaccid, but later fill up and then break or are rubbed open. After a few days the raw spot takes on a warty growth, vegetating with some rapidity, and becoming hypertrophic and spreading in serpiginous forms. These vegetations secrete a thin ichorous fluid, which dries into an easily removable crust.

The earliest points to be attacked are the labia minora and majora, the oral and buccal mucous membrane, the lips, the axillæ. Later, the vulva, the anus, and the mucous membrane of the rectum are attacked. Even the vaginal portion of the uterus does not always escape.

In the male the oral mucous membrane, the neighborhood of the symphysis pubis, the inner surface of the thighs, and the nates are first attacked, so that at first sight the eruption looks a little like eczema marginatum. Occasionally the scalp is involved. The process goes on in the oral cavity, fauces, pharynx, etc., until a pitiable condition of excoriation and fissuring is produced, and when, by reason of closure of the nasal cavity by the lesions, mouth-breathing is practised, the lips and mouth become so sore that even food is taken with difficulty. As the affection goes on, every portion of the surface may be involved, the vegetating element, however, becoming less conspicuous and the lesions becoming mere blebs and excoriations, so that the surface may look as if burned to the second degree. In the latter stages of the disease, which is fatal, the lesions may take on a kind of gangrenous action, and an intolerable stench pervades the patient's apartments. Finally death ends the painful scene.

The closely-grouped lesions of pemphigus vegetans, when these are seated about the mons veneris, thighs, and anus, resemble closely the eruption of condylomata lata. The following points will aid the diagnosis:

1. The growths of *P. vegetans* spring from the surface, only surrounded by the bleb-wall; those of condyloma are surrounded by an infiltrated ring.
2. The loss of epidermis and epithelium in *P. vegetans* gives the growth a stippled appearance which is absent in condylomata lata.
3. Condylomatous growths as the result of syphilis represent a certain activity of the disease-process, and are usually accompanied by other symptoms; while also the

tendency of the syphilitic eruption is to disappear in the long run, *P. vegetans* tends irresistibly from bad to worse, with constant decrease in the patient's strength.

Neumann gives notes of several cases of the nine which he has seen, and adds chromo-lithographs and microscopic sections illustrating the appearance of the lesions and their structure. He says that most of his cases were supposed to be syphilis, and much pain was caused by unfounded suspicion, not to speak of painful family scenes. This will excuse the rather full abstract above given.

LICHEN—LICHEN RUBER—LICHEN SCROFULOSORUM.

Vidal, in an article extracted from a forthcoming work on diseases of the skin (*Annales de Derm. et de Syph.*, t. vii. p. 133), appears to take quite a different view of the disease from that taken by the Viennese school. It is known that the Germans confine the use of the term lichen to one or two forms of disease, while the older English writers made it include a number of affections which the Vienna school masses under the all-inclusive designation of eczema or of prurigo.

Vidal takes quite a different view. He includes the prurigo of the Germans under lichen, and divides the latter affection into two main varieties: 1. Lichen simplex; 2. Lichen multififormis. The first of these he subdivides into acute, partial and general, and chronic, partial and general. The second variety is subdivided into mild and severe (*mitis* and *ferox*).

The varieties are described at some length, and with frequent use of expressions believed to have been long since obsolete, so that in reading this chapter one rubs one's eyes and wonders whether one has waked up in the times of Willan and Bateman.

This sort of thing will not succeed. It is useless to attempt to return to forgotten and forsaken nomenclatures and classifications.

A letter by Unna ("Sur la question du lichen") in the same volume of the *Annales* (p. 585) is chiefly taken up by a defence of an earlier article on the subject, but in it he gives expression to the following, which is worthy of attention by some of our younger dermatologists, who return from Vienna with the notion that all knowledge begins and ends there.

"That which we must guard ourselves against above all things is the influence of the 'school.' For the novice in science the school, with its established principles, its authoritative teaching, is an excellent institution, but it is a positive clog to the adept." In speaking further of the absence in Hebra's work of due acknowledgment of the labors of foreigners, Unna says, "The reason of this lacuna in the second edition of Hebra's work is to be sought alone in the peculiar custom of the Viennese school,—a custom which the 'system' of Auspitz and the younger Hebra's book are beginning to break through. This peculiar custom consists in declining to take the descriptions of foreigners in their intended meaning, but forcing them with more or less success into Hebra's classification, and adapting them to it whether or not. Our knowledge of impetigo contagiosa, of morphea, of urticaria pigmentosa, of lichen planus, of myxœdema, of the dermatoses, of filaria, etc., which we owe exclusively to the English, renders this preponderance which they wish given to the local experience of Vienna quite untenable."

Brocq maintains, against Unna, the view that lichen ruber acuminatus is the same as pityriasis rubra pilaris.

Cases of lichen ruber and lichen scrofulosus have been reported by Boeck in the *Monatshefte* (Bd. v. S. 435), and by Gottheil in the *Journal of Cutaneous and Venereal Diseases* (vol. iv. p. 133). Boeck's series of cases are interesting as presenting the milder type of the disease similar to that met with in this country, and also as confirming some of Unna's views regarding the varieties of the disease.

COMMENTS ON SOME OBSTETRIC OPERATIONS.

BY GEORGE H. ROHÉ, M.D.

NOWADAYS the value of every medical or surgical procedure is determined by statistics. If a sufficiently large number of figures—whether these represent facts or not doesn't seem to matter—can be got together in favor of any surgical operation or plan of medication, no one dares question the conclusions drawn unless he can present a larger number of figures apparently proving something else.

At first sight there is nothing so unsym-

pathetic as figures. As a matter of fact, figures themselves, in their proper places, never lie. But mortality statistics comprise something beyond the bare figures of so many cases, so many recoveries, so many deaths. They must take into account the circumstances of the cases in the literal meaning of the word,—i.e., "matters attending an action that modify it for better or worse." This important point is too often completely lost sight of. The claims of partisans are always one-sided, and disfavoring events are ignored or suppressed.

Coming back, however, from this slight digression, I must point out first the power of precedent in obstetrical art. When it is considered that the problems to be solved in the delivery of a fœtus are so largely physical, it is certainly remarkable that the dicta of authorities are held in such profound veneration, and thinking for one's self is such a rarity.

The views to which I would give expression in this paper are the result of considerable reflection, and, although perhaps based upon insufficient personal experience, will, I trust, commend themselves as the result of the application of common sense.

The dictum of the old English master of the art, that "All meddling midwifery is bad," might, I think, be appropriately modified so as to read, "Ignorance in midwifery is bad." No one should be permitted to undertake the conduct of a case of labor who is ignorant of the mechanism of the process. This seems a bald truism; and yet it does not seem entirely superfluous in the light of our everyday experience.

I venture to assert, as a general rule, that in obstetrics there are no operations of election: either an operation is indicated or it is not indicated. It is the obstetrician's duty to make himself familiar with the conditions indicating the appropriate procedure to be adopted in any special case.

In all cases of labor, normal or abnormal, nature should be given a fair chance to do what she can towards effecting delivery. This does not mean that an unreasoning confidence is to be placed in the natural powers, but that no premature intermeddling should take place until the capacity of nature to deal with the case has been carefully measured. It does not

mean, either, that even in perfectly normal cases the accoucheur should leave matters entirely to the natural resources of the mother. Judicious aid rendered at the proper time, whether in the way of supporting the perineum, compressing the abdomen, expressing the placenta, or applying a binder after delivery, will be not only grateful to the patient, but often extremely valuable, although sometimes characterized as "meddlesome."

Let us take, however, a case in which nature's obstetric powers are insufficient, and in which art must step in to render assistance. How shall we be able to determine upon the indications for the various procedures?

In cases of slight disproportion between the head and parturient canal, if artificial delivery is necessary, it is usually held that the choice of operations lies between the application of the forceps and version by the feet. If each case be carefully and understandingly studied, however, it will be found that there is no choice allowable in a true scientific employment of the obstetric art, but that either the one or the other method must be adopted. There is no alternative.

Should the head present in an appropriate position, and the disproportion be due to a large head or slight uniform contraction of the pelvis, the os be well dilated, and the head engaged at the brim, but arrested there or in the cavity, the operation indicated is extraction with the long forceps. So long as the disproportion is not considerable enough to prevent the delivery of an unmutated child, forceps extraction is not an operation of election, it is one of necessity, and the practitioner who considers any other procedure in such a case can lay no claim to being a scientific obstetrician.

If, on the other hand, there should be antero-posterior flattening of the pelvis, with moderate shortening of the transverse diameter so that the head cannot engage, or a malpresentation of the cephalic extremity such as a face- or brow-presentation, the correct indication would be to perform version and delivery by the feet. The indications for this operation are not, however, sufficiently known to allow a general rule to be laid down. Further study and observation are necessary.

The range of these two procedures is limited by a pelvic coarctation to three

and one-fourth inches in the antero-posterior diameter. It is true that several obstetricians claim to have delivered living children by version in cases where the conjugate diameter was less than three inches; these are exceptions, and cannot be considered in establishing a general rule.

When the pelvic contraction is below three and one-fourth inches, or the diameters of the child's head are much greater than usual, on account of disease or malformation (hydrocephalus or certain forms of monstrosity), the disproportion between the head and the genital canal must be adjusted by one of the bloody operations either upon the child or the mother, — namely, craniotomy or Cæsarean section. Unfortunately, the diameters of the pelvis are not the only factors to be considered in establishing the indications for craniotomy. In some cases the child's head, as just pointed out, must also be taken into account. Inasmuch as in a large proportion of cases no trustworthy estimate can be formed of the size of the head in utero, it is sometimes difficult to reach a satisfactory conclusion, for so long as there is hope that the child may be saved and the life of the mother not endangered by the delay, craniotomy will be deferred. This doubt is more apt to arise in the lesser degree of pelvic contraction. When the conjugate diameter is less than three and one-fourth inches no hope may be entertained of delivery of an unmutated child by the natural passages, and either craniotomy or some substitute for it must be performed in order to give the mother the best chance of life.

When the antero-posterior pelvic diameter is between two and a half and three and one-fourth inches, most obstetrical authorities advise craniotomy; if less than the former, Cæsarean section. With a pelvic canal of between two and a half and three and one-fourth inches antero-posteriorly, and no great encroachment upon the canal laterally, the child's body, decreased in size by perforation of the cranium and excerebration, can be delivered *per vias naturales* with comparatively little danger to the mother. The older statistics of craniotomy give a mortality of mothers as high as twenty per cent. Churchill's table gives two hundred and eighty-six cases with fifty-five deaths (19.2 per cent.); but this includes one hundred and twenty-eight cases with thirty-one deaths (twenty-

five per cent.) from the Dublin Lying-in Asylum, a hospital notorious for its high mortality-record. Smellie had forty-four cases with four deaths (nine per cent.), Churchill himself the same percentage, and Dr. Ramsbotham thirty-four cases with five deaths (14.7 per cent.).

Of the more recent statistics may be mentioned Schauta's, who had a mortality of 10.9 per cent. in seventy-three cases operated upon in the second Vienna obstetric clinic between 1876 and 1881.

In 1880 the late Professor A. F. Erich published a paper in which he gave the histories of eighteen consecutive cases of craniotomy in private practice without a single death. Between the date of publication of those cases and his death Dr. Erich performed the operation twice to my knowledge, both without any ill effect to the mothers. In one of these cases, in which I assisted, the woman (primipara) had been in labor for twelve hours. The patient had been under the care of a midwife, who had, in accordance with the custom of that class of practitioners, administered ergot in order to hasten the slow labor. The membranes had ruptured hours before, and the genital passage was hot, dry, and tumid. The head was large, and was arrested at the brim, into which it was forced firmly by the forcibly-contracting uterus. The patient was irritable and feverish. Version could not be performed. The antero-posterior diameter was not much diminished; I judged it to be about three and one-fourth inches. With the long forceps of Hodge earnest attempts to deliver were made, but without success. The indications were plain that craniotomy should be performed. The cranium was skilfully perforated by Dr. Erich, the brain broken up and evacuated, and in a few minutes a large child was delivered. The mother recovered without an unfavorable symptom.

The other unpublished case of Dr. Erich above referred to occurred in the practice of Dr. Shertzer. Owing to absence from the city at the time, I did not have the good fortune to see this case, which was described to me as one of extreme pelvic malformation. This case also recovered.

About two years ago, I had an opportunity of assisting Professor Opie in a case to which he had been called in consultation by the attendant, a physician with a large obstetric practice. The patient had

been in labor for thirty-six hours. The forceps had been faithfully tried after the labor ceased to progress naturally, but without avail, although the pelvic space appeared ample. Professor Opie diagnosed a hydrocephalus, and, after perforating and evacuating a large quantity of water, a dead child was speedily born. The patient, who had been much exhausted by her tardy labor, rapidly recovered.

In the summer of 1885 my aid was requested by a professional friend in the case of a colored woman in labor with her first child. She had been in travail about twenty hours when I saw her. The forceps, which had been frequently applied before my arrival, were again tried repeatedly, but without avail. No progress was made, although the pelvis was roomy and the cranium was not impacted. I suggested version, and on attempting to introduce my hand into the uterus discovered a large dropsical head. Perforation was indicated and performed, and, although the woman lived in a dark and damp basement-room in a filthy alley, she recovered promptly.

Five years ago I delivered a woman by craniotomy upon the after-coming head after decapitation. The patient had been twice delivered by craniotomy before by Professor Erich, and had declined the advice to have labor induced in the seventh month. The forceps were persistently applied, but on account of a considerable antero-posterior contraction the head could not be made to engage. I am now convinced that the persistent use of the forceps in this case was bad practice. Hoping to deliver a living child, I turned by the feet without much difficulty, but failed utterly in getting the head through the brim. The child was large, and perforation could not be accomplished before decapitation had been performed. The head was then perforated, and the skull broken up with Meigs's forceps and delivered. The patient, however, succumbed to shock, doubtless induced by the prolonged efforts with the forceps and the version. I am confident that an early craniotomy would have saved this woman's life. It was the operation indicated by the circumstances of the case.

A case similar in some respects was seen with Professor Erich. The patient had been in labor about twelve hours under the care of a midwife; but, as the head did

not engage, she wisely refrained from giving ergot. The forceps were applied under anæsthesia, and efforts made by both Dr. Erich and myself to deliver, but without success. Dr. Erich, with his usual practical sagacity and clear vision, saw that craniotomy was indicated, and proposed that operation. I appealed to him, however, to try and save the life of the child if possible. Contrary to his judgment, he yielded, and performed version without trouble, but considerable difficulty was met in extracting the child, which was born dead. The woman suffered considerably from shock, but rallied, to succumb on the fourth day to septicæmia.

To the twenty-three cases of craniotomy here related may be added three cases recently reported by Dr. H. J. Garrigues, of New York, none of which proved fatal. We have then twenty-six cases, with but a single death (3.8 per cent.). If in one of the cases the indicated operation had been performed at first, probably there would have been no fatal case to record in this series.

Craniotomy is contra-indicated when the conjugate diameter of the pelvis is less than two and a half inches. It is true that in some cases where the contraction is greater than this the mutilated fœtus could be delivered; but generally the operation is fraught with grave dangers to the mother. In Parry's statistics of seventy cases of craniotomy in pelvis measuring two and a half inches and under, twenty-seven died, a mortality of 38.6 per cent. Doubtless, with antisepsis, much more favorable results could be obtained; but for these cases Cæsarean section is indicated; for while the dangers to the mother are very little increased by this operation, a considerable proportion of children might be saved. The more recent statistics of the Cæsarean section with suture of the uterine wound and its peritoneal covering are very favorable, although the American operators have fared very badly. Out of fifty operations by thirty operators since 1880, fifteen women were lost, a mortality of thirty per cent. But forty-three (possibly forty-six) children have also been saved. Of five operations done in the United States, however, all of the mothers and three of the children were lost. However, in the three lying-in institutions of Leipsic, Dresden, and Innsbruck, out of twenty-four cases only one woman died,

and all the children were saved,—a result so remarkable that one would be tempted to question the accuracy of the statistics if they were given on the authority of a less trustworthy writer than Dr. Robert P. Harris, of Philadelphia.

In all pelvic coarctations below two and a half inches in the antero-posterior diameter, then, the Cæsarean section should be performed; it is the only one indicated in these cases. But between two and a half and three and one-fourth inches craniotomy must still be regarded as the only operation compatible with safety to the mother.

The foregoing remarks are applicable to cases in which gestation has been completed or labor has begun. If the patient is known to have a contracted pelvis and the physician is consulted before the termination of the pregnancy, another procedure, the induction of premature labor, must be considered. This is indicated when the antero-posterior pelvic diameter is greater than three and one-fourth inches. In a pelvis having a shorter diameter than this, the delivery of a living or viable child is rarely accomplished by premature labor. The increased danger to the child at that age with a pelvis narrowed to three and one-fourth inches is due to the compression to which the head is subjected in passing through the canal. Inasmuch as the induction of premature labor is accompanied by more danger to the mother than craniotomy, the latter is indicated in pelvic diameters between two and one-half and three and one-fourth inches. If below the former diameter, Cæsarean section should be performed, primarily in the interest of the mother.

From the facts above stated, the following conclusions may, I think, be justly drawn:

1. The forceps, properly used, are the best means to aid nature in effecting delivery in head-presentations where the disproportion between the head and the genital passages is not too great to prevent delivery of an un mutilated child by the natural passages. In certain cases, especially of antero-posterior contraction, podalic version is the properly-indicated procedure. But in the present state of obstetrical art no definite rule can be laid down for the guidance of the practitioner in these cases.

2. In cases of pelvic contraction down to two and a half inches antero-posteriorly,

or of cranio-pelvic disproportion from other causes, if the forceps has failed, craniotomy is the only rationally-indicated operation, irrespective of the life or death of the fœtus. Fruitless waiting until the child dies by process of nature is reprehensible, and may, by adding dangers to the mother, become criminal. In these cases Cæsarean section is not an operation of choice or election.

3. In cases where the coarctation of the pelvis is extreme,—below two and a half inches,—or where there is extensive carcinomatous disease of the cervix or rupture of the uterus, the modern Cæsarean section with suture of the uterine wound, hysterectomy (Porro), or gastro-elytrotomy is indicated. Here also the operation decided upon should not be delayed until the dangers to the mother are too much increased.

4. In cases where the antero-posterior contraction of the pelvis is not below three and one-fourth inches, and the condition is known to the obstetrician before the pregnancy has terminated, the induction of premature labor in the seventh or eighth month may result in the delivery of a living and viable child.

5. The high forceps operation, version, craniotomy, Cæsarean section, and the induction of premature labor can only in very rare instances be considered as operations of election. Each has its definite sphere, when it should be employed, and in which it cannot be substituted by any of the others. It is only in very exceptional cases, conditioned by special circumstances, that this rule is suspended. In these cases the judgment of the experienced obstetrician, after taking into account all modifying circumstances, must decide which procedure is to be adopted.

TRANSLATIONS.

HEPATIC ABSCESS IN CHILDHOOD.—Dr. A. Bernhard reports three cases of abscess of the liver occurring in children (*Jahrbuch. für Kinderheilkunde*, N. F., vol. xxv. 4), and observes that, although less disposed to suppurative inflammation of the liver than in later life, yet cases of liver-abscess in childhood are not of such rare occurrence as is usually believed. The predisposing causes are the same in childhood as in adults, except diseases of the gall-ducts and gallstone abscesses, which

in children hardly ever occur. The symptom-complex is very varied. For diagnostic purposes the following will serve:

1. Chills, with irregular, intermittent fever, in diseases affecting the area of distribution of the portal vein, are the most important and most constant symptom of suppurative hepatitis, with the possible exception of pain in the liver.

2. In abscesses of the liver complicated with pleuritic exudation, the line of dullness may be higher in front than at the back, and is generally irregular. In such cases experimental puncture can be performed, and the diagnosis made clear, if from above serous, and from below purulent, contents are withdrawn. Such aspiration is without danger when antiseptic precautions are observed. The putrid character of the pus, and the absence of fetid breath and of the characteristic signs of pulmonary gangrene in the sputa, point to a disease beneath the diaphragm, and to liver-abscess as the probable cause.—*Deutsche Medicinal Zeitung*.

SUCCESSFUL TREATMENT OF DIABETES.

—An interesting note was communicated by M. Martineau, physician to the Lourcine, to the Société de Thérapeutique, upon the treatment of diabetes. Within twelve years he has had the good fortune of obtaining sixty-seven definitive cures out of seventy gouty diabetics treated by the lithiated arsenical water. The mode of administration had been suggested by Prof. Rouget. It consisted simply in placing in the upper globe of a seltzer-water apparatus (Briet's), holding about a litre,—

1. A packet containing twenty centigrammes of carbonate of lithia;

2. A tablespoonful of a solution of arseniate of sodium (twenty centigrammes in five hundred grammes).

This is to be drunk at meal-time, mixed with wine. The contents of the apparatus should be enough for three meals at least.

The diet is not changed, or is somewhat restricted as regards starch, sugar, and fruits.

No special treatment was followed, and it is to the above prescription that the results were to be attributed. The result is not obtainable by lithia or arsenic given separately. Having waited to test this thoroughly before recommending it to others, M. Martineau felt warranted in demanding for it a fair trial.—*Revue de Thérapeutique Médico-Chirurgicale*, March 15.

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EDITORIAL.

CONDURANGO REDIVIVUS.

GERMAN medicine has generally been regarded as almost synonymous with therapeutic scepticism. It must cause surprise, therefore, when a drug held in so little esteem in this country as condurango should claim the serious attention of eminent practitioners in Germany as a remedy possessing specific virtues in gastric cancer. American physicians have not had a very happy experience with condurango: in fact, if we remember correctly, its meteoric appearance in our therapeutic firmament raised quite an ethical controversy, the *disjecta membra* of which still occasionally turn up at the mention of certain names. But, having for a number of years rested in "innocuous desuetude," condurango has during the last two years received considerable attention from such notable authorities as Rühle, Binz, Immermann, and Riess. The latter, who is medical director of the Berlin City Hospital, in an article published in the *Berliner Klinische Wochenschrift* reports a large number of cases presenting the symptoms of cancer of the stomach, in which the drug was used with good results. Riess states that, as the result of his experience in upwards of one hundred cases, the remedy was not without success in a single case. From full notes of eighty of the cases treated with condurango and one hundred and sixteen treated without this drug, he has constructed a table which shows the following instructive results:

Of a total number of 80 cases which were treated with condurango, 53 died (66.3 per cent.), with an average duration of treatment of 39.5 days; the remainder, 27

(33.7 per cent.), were discharged (24 "improved," and 3 "cured"); they were under treatment for 54.8 days on the average. Of 116 cases treated without condurango, 107 died (92.2 per cent.), the average length of treatment being 22 days; the remainder, 9 (7.8 per cent.), were discharged (5 "improved" and 4 "unimproved"), the average duration of treatment being 11.7 days. Thus the average length of treatment of cases using this agent was 43.4 days, or nearly double that of those not so treated (21.2 days). The proportion of cases benefited by treatment with condurango was much larger, and the deaths were notably fewer.

In about twenty-five per cent. of the cases in which a distinct tumor of the stomach could be made out, the growth diminished, according to actual measurement, during the treatment. In twelve per cent. the growth disappeared almost entirely.

Riess claims that the effects of the drug are not simply those of a stomachic tonic, but that it seems to have a specific action in modifying the local and constitutional manifestations of the morbid process, and even, in favorable cases, arresting the latter.

The method of administration adopted by Riess is the decoction (one to twenty), of which six ounces are given per day, combined with syrup of orange-peel. In some cases he gives it in tablespoonful doses every hour. Patients do not object to it, as they so often do to other medicines in this disease. Immermann advises the wine of condurango as a good preparation.

Remedies for cancer of the stomach are not so plentiful that the profession can afford to reject any one recommended so highly as this one is by competent and experienced practitioners, without a trial. Further observation may cause us to revise the unfavorable judgment pronounced upon condurango by American physicians fifteen years ago.

PRÆPERITONEAL LIPOMATA.

HEINECKE, Wernher, and others have called attention to these curious and little-known tumors as the cause of certain obscure chronic painful affections of the abdomen. In recent numbers of the *Allgemeine Wiener Medizinische Zeitung*, Thonmayer has recorded six observations and placed the whole subject upon a practical basis. According to this observer, its omission from systematic text-books constitutes a serious defect in medical teaching. Præperitoneal lipomata occur most frequently in the linea alba. They consist of little fat masses which press through small openings in the fascia and develop underneath the skin. In the linea alba they occur with greatest frequency between the umbilicus and the ensiform cartilage; rarely they are found above the symphysis. They are of small size, not often attaining the measurement of a walnut, and can more commonly be felt than seen; upon pressure they are often exquisitely tender. Their presence is of importance because they tend to draw after them little pouch-like processes of peritoneum, and thus favor the development of herniæ. Quite aside from this danger, they are of clinical importance as causing pain, vomiting, and meteorism, and simulating various painful affections of the gastro-intestinal tract. The pain is due to traction upon and irritation of the peritoneal process, and may suggest colic, neuralgia, dysmenorrhœa, and the like. It vanishes upon the reposition and retention of the tumor, or upon its extirpation. Præperitoneal lipomata are to be diagnosticated from herniæ by their small size, their elasticity upon palpation, and their marked sensitiveness. Treatment consists in their reposition and retention by a compress and belt. Reposition by taxis is usually easy, and a small opening may often be detected at the site of the little tumor. Thonmayer's cases, with the exception of one in which death occurred from other causes, were at once and

permanently relieved. In view of these statements, systematic examination of the abdominal wall, particularly in the median line, should be practised in all obscure long-continued painful affections of the abdomen.

NOTES FROM SPECIAL CORRESPONDENTS.

PARIS.

T*TREATMENT of Malignant Tumors of the Bladder.*—At the late Congress of Italian surgeons held at Genoa during April of this year, Professor Novaro, of Sienna, presented a dog in good health in whom he had, some three months before, successfully transplanted the opening of the ureters from the bladder to the rectum. This is a very important fact for modern surgery as regards the history of cancer of the bladder. Signor Novaro said, "I do not believe in the usefulness of any palliative operation in these cases, and I think it is preferable to attempt a radical operation which consists in the complete extirpation of the bladder. I have several times done this operation in dogs, and I have succeeded in taking away the bladder after having placed the ureters in communication with the rectum. The operation should be done as follows: first, an incision in the hypogastric region should be made, circumscribing a large flap with its base above, taking in all the thickness of the abdominal walls. Having uncovered the bladder, the ureters are attached to the rectum and the bladder taken away.

"It is only recently that surgeons have dared to attack the urinary bladder to get rid of the neoplasms that may have developed themselves at the expense of its substance. The deep position of the organ and the complex nature of the operations explain the present abstention. But cancer of the bladder is, of all the growths that may take place in the bladder, one that seems to have the least tendency to generalize itself, so that complete extirpation of the organ seems to offer the very best chance of cure. Professor Guyon has shown why this is true. To understand it is easy when we remember that the bladder possesses an anatomical structure quite different from most of the other organic structures, for M. Sappey says that its walls are deprived of lymphatics. This is intended by nature to prevent re-absorption of the urine; and we all know also that it is just these lymphatic vessels that are invaded by the elements of malignant tumors, and by them they extend to the whole economy and render most surgical operations useless, or at best only palliative in nature. However this

may be, the clinical fact is certain that whenever cancer takes its birth in the bladder it is likely to remain there, during a long time at least. So that, if its complete extirpation is made possible, a radical cure is obtained for cancer of the bladder. It is true that to conclude from operations on animals to man is not so easy as it seems, but still it is not impossible to believe that, with modern methods of antiseptic and improvements in operations, this dreaded disease will have found a radical cure before many years."

Chloroform and Tracheotomy.—A long discussion at the Paris Surgical Society on this question, and a late clinic by Dr. De Saint-Germain, give some varied views as to the advisability of using chloroform in tracheotomy. M. Le Dentu brought the subject up at the Société de Chirurgie by reading a paper sent in by M. Housel, of Boulogne, who advocated its use. M. Le Dentu thought that it was never used, and several of the members stated that it was as old as Chassaignac, and that it was "current money" in America. The opinion was much divided, but most inclined to the ideas expressed by Dr. De Saint-Germain in his clinic at the Hôpital des Enfants-Malades, so we will give a *résumé* of what he said, as his great experience deserves attention. It may be stated that his method of operation is of the one time and one motion order. The doctor said, "I have been asked why I did not take part in the discussion at the Surgical Society on the use of chloroform in tracheotomy. Well, to tell the truth, my ideas were not clear at the moment as to what answer should be made to this proposal,—something like the people who only find their brains at the bottom of the stairs. I talked it over by myself afterwards, and now that I am more at home in our little amphitheatre I will tell you what I think about the matter. I may be pardoned first for stating that I have made four hundred and two tracheotomies, and I have given chloroform thirteen thousand times, so I am not afraid of it. In nineteen the operations were made in adults, and seven I saw made by Krishaber. I have always been astonished at the resignation and calm displayed by the patients during the operation, and, asking them about the pain, they mostly answered that it hurt less than to have a tooth extracted or to have a boil opened. I have never seen any occasion to give chloroform, nor have I seen it given, and think it would be more of an impediment than anything else. As to children, it is demonstrated to-day that there is no use in operating early, so we wait until the last moment,—that is to say, when asphyxia has already commenced,—and it is well known that the child is at that moment in a state of anæsthesia, so that in this group of cases there is no use for chloroform.

"I now come to the cases where the child

is not in the state of *perinde ac cadaver*, but is strong and ready to defend himself. Suppose the surgeon called in the middle of the night by a distant doctor to operate upon a child suffering with croup. Upon his arrival he examines the child, who in fear defends himself, clinging to the curtains and suffering from suffocation, but not yet with asphyxia. The parents object to the operation, and it is possible to wait an hour or two longer; but the surgeon must then go home, perhaps to be called when it would be too late: so the operation is decided upon. And here chloroform might render good service, it might be thought; but, first of all, the surgeon will need two aids, and it must not be forgotten that, as he has chloroformed the child, he must do the slow and dry operation indicated by Trousseau. But what risks with an anæsthetized child you run! If you let fall into its trachea a flow of blood, of which it cannot have any consciousness, and which it will not, therefore, make any attempt to reject, I leave you to imagine what happens if this blood is not expelled.

"Of the considerable number of children that I have operated upon, two died on the operating-table notwithstanding all I could do to save them: the first one from a mass of false membrane that the canula pushed down, and which I could not extract; the second from a syncope that seemed to take place on contact of the knife with the skin. Since that time I always address the parents about as follows: 'Your child will be certainly lost if it is not operated on at once, and tracheotomy gives it one chance in five of cure; but I must tell you that the operation itself is not without danger: for, notwithstanding all the care I may take, it is possible for the child to succumb in the middle of it. But, no matter what that danger is, I should not hesitate to perform the operation on my own child if it were in the state which yours is in at present.' I don't remember any parent that objected after such a speech; but if we add the danger of chloroform to the operation, can we say the same thing? No."

As a sort of *post-scriptum* to the above, it is interesting to say that Professor Brown-Séquard has made a number of experiments in his laboratory on dogs and monkeys, by which he proves that an incision of the skin made along the middle line of the neck will at once bring about an anæsthesia of the region in a radius of six to seven centimetres. Dr. Brown-Séquard was astonished to find, in the accounts given of people who committed suicide by cutting the throat, that they sometimes went on almost to sever the head, and with most people he thought it was a sort of insane courage. But on investigating the matter by experiment he found that even a slight incision of the skin of the neck produced an anæsthesia of the region. This was also studied to see how analgesia could be produced. It results from the facts shown by

Dr. Brown-Séguard that the skin of the neck possesses, in common with the larynx, but to a less degree, the power to inhibit the sensibility. So, if the surgeon can make the part insensible by a bistoury-cut, what is the use of chloroform in tracheotomy?

Treatment of Cold Abscess.—Dr. Barette, the present *chef de clinique* at Professor Trélat's service, gives in a late article a good account of the cure of these abscesses, which are so common all over the world. First of all, he calls attention to the fact that these patients are not only attacked with a local disease, but that their constitutions are more or less involved: so that we should not look upon it only in the surgeon's light, but also give a general treatment, which must vary with the patient. Hydrotherapy is important, exercise out of doors, and daily salt-baths (five pounds of rock-salt to the large bath-tub of water). To this add good food, milk, etc. Almost all the preparations containing iodine are good, and the best is cod-liver oil, four to six tablespoonfuls per day. When the stomach refuses to digest it, then change to iodized glycerin (two grammes to one hundred and fifty of glycerin), or iodized wine (one gramme of tincture of iodine to a quart of good Bordeaux wine). Or use the syrup of the iodide of iron. Change of climate, the mineral waters, and above all the sea-side, is to be recommended for those who can go or be sent. The maritime atmosphere, charged as it is with sodium chloride and vapors of iodine, with ozone, seems to penetrate the organism and forces internal combustion to its highest limits. Besides, here is to be found one of the most active forms of treatment, the cold salt-bath. Quite recently Dr. Cazin, of the hospital at Berck-sur-Mer, a hospital at the sea-side mostly for children, and M. Lejeune, of the Institut at Ostend, another sea-side curative establishment, showed what excellent results could be obtained by such institutions. They also give a sort of mucilaginous bath, formed of sea-weed and water, which contains a strong proportion of the iodine principles. (There is a chance for some one to erect such hospitals at Atlantic City or Cape May.)

As to local treatment of these cold abscesses, at present the modern methods here are but two in number: one is the injection of ether-iodoform, and the other is opening and scraping out. The first is Professor Verneuil's method. He thinks that iodoform is the best substance to destroy the bacillus of tuberculosis, and he added the ether to it so that its vapor would carry the agent to the remotest parts of the abscess. The iodoform is also absorbed, as can be proved by the examination of the urine, where it will be found: its action is powerful in modifying the constitution.

The injections used are one of iodoform

five, ether one hundred, and a strong one of one iodoform to one hundred ether. First Dieulafoy's aspirator is used, No. 3 needle, and without changing the trocar the injection is made, not over three or four grammes being used in the large abscesses. The walls then swell up to quite a large size, but no one need be alarmed, at this, as it gradually goes off, and cure often follows. We will not describe the well-known system of surgical intervention by large incision and *grattage*, but we may state that in very large abscesses, where all surgical aid is impossible, we have seen these injections bring about a very considerable amelioration of the general health of the patients.

False Testimony of Children: its Medico-Legal Aspects.—M. Motet lately related to the Academy of Medicine some very interesting facts on this subject, that can be applied by any physician who may be called in to elucidate such cases. There is nothing more moving than to hear a child tell the details of a crime which he pretends to have witnessed or has been the victim of himself. The natural way in which he speaks, and the simplicity of all his facts, give confidence, and public indignation goes on increasing as he tells his simple tale. One can hardly believe that they often invent it all, but such often is the fact.

M. Motet tells of a number of cases to prove this. One is of a little boy of seven, who did not come home all one night, and the day after he was taken out of the river, where he had thrown himself with the evident intention of drowning himself. His story was that a man, of whom he made a correct description, had met him and carried him off by force, and that finally he had thrown him in the river. His description of the man was so exact that the police had no trouble in finding the person, who was employed in the neighborhood in a museum of anatomy; but he quickly proved an alibi and was released. M. Motet was charged with the examination of the child, and in questioning the mother he found that for some time back he had slept badly, and that he had incontinence of urine; besides this, he lived in conditions that must have worked on his young imagination, for his mother was a newspaper-seller, and every day he heard of all sorts of crimes and scenes of violence. To add to this, the man he charged had lately come to settle in the neighborhood with his wax-show of anatomical horrors, and the child heard him crying out one day, "Walk in and see the head of Morin, who was killed by Mrs. H." (a celebrated murder-case of last year). It happens that the boy's name is Morin, and here was the moral shock which led to the whole trouble. No doubt the child, haunted by fear, took to dreams, and the idea of some danger menacing him was implanted in him. So one

day he is taken with a fright, and runs off to end it by jumping in the river. (The youngsters who run off after a course of the ten-cent novels to kill the Indians furnish an example of the same type.)

A curious one of the same style is that of a young fellow who walked in his sleep. Seen at the Hôtel-Dieu a few days ago, he seemed healthy, but it was stated that at night he got up and walked asleep, or sometimes fell down in a sort of fit, during which he said people did all sorts of things to him, and it might have led to a charge of some criminal sort. The doctors were puzzled a little, and all sorts of diagnoses were made, including epilepsy and hysteria, etc., until it was found that he had worms, a cure of which took away all the symptoms. Certainly the moral is that a doctor is to be called in to investigate these cases, and not a lawyer.

A similar case was that of a young man who was locked up in prison on some charge of petty theft, and made charges against his guardians that they had entered his cell at night and made obscene attempts on him. Worms again; and these, combined with sensations of anal pruritus and his unhealthy imagination from reading novels and bad books, led to his making charges that could only be cleared up by a medical investigation. So that it is to the medical profession, after all, that we must look for the clearing up of these delicate questions.

We must all remember in regard to children that their growing intelligence is always ready to seize upon the marvellous side of everything, that fiction of all sorts charms them, and that they have a most astonishing facility in giving a body to fictions they hear or read. Again, the little ones are generally influenced by a nervous mother, who will question them in such a way as to suggest to them a certain line of ideas which they will follow. Witness the case here lately of the little boy who plays truant from school, and, returning, his mother fancies from his garments being deranged that some wicked attempt has been made on him. She questions him from this point of view, and he, not knowing what to say, assents to what she says, and on the father's return repeats all as she says it to him, and the poor man, scandalized, goes for the grand question, Who did it? and, forced, as it were, to answer, the child names a neighbor, who is at once arrested and has some difficulty in proving an alibi. Professor Charcot has frequently shown cases like this. Some weeks ago a young hysterical girl, during a period of mesmeric state, was told that she had been given a loan of fifty francs. Another day she was asked where and how she got a certain piece of gay ribbon she was wearing, when she at once stated that she had gone out one afternoon and bought it, and got it in a certain street which she named, and that she paid twelve francs for it. In analyzing this it

was found that it all arose from the suggested loan of the fifty francs, which was never given to her; this had passed in her brain as a fact, and she at once invented the rest, as she had not been out of the hospital, and the ribbon had been left there for her by one of her relations without her knowledge. In legal medicine a careful study of these facts, with clinical experience, will mostly be enough to clear up many a difficult law case, if followed up with a little patience by a careful physician.

Treatment of Angina Pectoris.—Recent discussions before the Société Médicale des Hôpitaux have brought this question to the front. Two theories are brought forward to explain the very painful attacks that characterize this malady. One is the nerve-theory, which looks upon these manifestations as a neuralgia of the cardiac plexus, and attributes the serious cases to a sort of neuritis of the same plexus. This neuritis was discovered anatomically in 1863 by Lancereaux, and it was well developed by Professor Peter as long ago as 1871.

The second theory is the arterial one, which attributes angina to an organic stricture or a spasmodic one of the coronary arteries of the heart, and in general to all the various causes that bring about an ischæmia or anæmia of the myocardium. This theory, spoken of by Hunter, Parry, and others, had been abandoned, but has been taken up again by Germain Sée and Potain, and it has again been upheld by M. Huchard during the recent discussion. For this last author the attacks that have been observed in neuropaths, and which have been invoked to sustain the nervous theory, are *false anginas*, and these pseudo-anginas show themselves at all ages. They are characterized by the frequency of the attacks and by their periodic appearance, often at night; also by their duration, which is often very long, and by the seat of the pain, which is at the lower part of the cardiac region. The nature of these pains is similar to a sensation of fullness or tension of the heart; they are more painful than dangerous, and cure in every case, notwithstanding the medicine given or the doctor attending. A recent thesis calls them "angina of the chest of an hysterical variety."

What a difference there is between the real attacks of angina pectoris and these symptoms! says M. Huchard; for in true angina pectoris it is particularly to the age of the affection of the arteries, such as arterio-sclerosis, that we must look: as a great physician said about this, "A man has just the age of his arteries." Again, the attacks are not often spontaneous, and mostly come on after a quick walk or some unusual effort, or even a simple movement which is so quick that a patient of Parry's is reported to have said that "he felt the extremes of pain and feeling well in an instant." The pain is also exactly under the sternum, and it is agonizing while it lasts: as Seneca said, who was himself a sufferer, "For

all other pains one suffers, but in this one seems to give up his soul." Real angina left without treatment almost always terminates by death, and the explanation of its gravity is found in the concomitant lesion,—that is, the state of anæmia of the myocardium, which is proved by the sudden cases of death or faintness without pain.

The anatomical proofs are as convincing as the clinical, for M. Huchard has some ninety observations where the lesions of the coronary arteries are shown, and in experimental physiology the spasm of the coronary arteries is admitted. It is true, however, as M. Moutard-Martin says, that there do exist some cases of obliteration of these arteries in which no angina was observed, but it may be that here the collateral circulation had time to take place without bringing on any of the effects of cardiac anæmia. These theoretical ideas have an important practical importance, because if the attacks of angina are nothing more than anæmia of the heart's substance, and exist only in cases of aortic and arterio-sclerosis, they present a double elevation of the arterial pressure, and we must therefore abandon all the therapeutical measures that are capable of increasing *vaso-constriction* and arterial tension, such as digitalis, ergot of rye, and belladonna, and give, on the contrary, those medicines that produce *vaso-dilatation* and the diminution of the vascular tension. This is why nitrite of amyl and nitro-glycerin, which was spoken of by Lauder-Brunton, produced such good effects in attacks of angina pectoris, and for the same reason injections of morphine did good, but they could not cure the disease that the arterial trouble caused. For this purpose the use of the preparations of the iodide of sodium is proposed, as they have a special action on the arterial walls, while they cause the arterial tension to fall considerably, and the result of M. Huchard's experiments is that this preparation constitutes the real and only cure for this condition. He says that the potassium iodide when long continued becomes a heart-poison, and the sodium salt must be given. He gives it for fifteen to eighteen months at a daily dose of one to three grammes, with an interval of a week's rest in each month. His statistics give a result that the mortality has fallen from ninety-five to thirty per cent. of cases.

It must not be supposed that during this discussion M. Huchard and those who follow his ideas had it all their own way, for while some said that they had success with it, others, such as M. Guyot, said that they had given it without any success; but the near future will decide if M. Huchard is as correct and as sure of his facts as he says, for every case known is now being carefully studied, and further results will be ready in time for the International Congress meeting at Washington.

VOL. XVII.—18*

The Congrès d'Ophthalmologie.—There is a very interesting yearly meeting of this Congress now being held here, and a large attendance of eye-surgeons is present. We notice the name of G. T. Bull, of New York, who presents a new optomètre. Professor Panas, Landolt, and all the prominent men have presented papers, but they are too long for our letter. We will only call attention to some remarks of Dr. Abadie, of Paris, "on the importance of local medication in ocular therapeutics." He said that formerly they looked only to the constitution of the patient and the hope of a reaction of the organism, but now, while still taking into account the nature of the subject, an attempt is made to destroy the pathogenic element directly: as an example of this may be cited lupus of the face, which all the anti-scrofulous medicines do nothing to stop, and yet scarification and cauterization with the galvano-cautery will cure it readily. No ophthalmologist will deny the good effects of yellow precipitate in the scrofulous ophthalmias of children; and, thanks to the use of cocaine, new local applications can be tried. "So we have lately incorporated iodoform with lanoline, which has a great penetrating power, and we have obtained excellent results in tuberculosis of the iris with daily massage of the eye with a pomade made in this way. In the choroid diseases, where the mercurial medication is indicated it also combined with lanoline will permit the drug to penetrate into the thickness of the ocular membranes, where it is hoped the curative influence will be still greater. With lanoline we have all the elements of a new local eye-medication which is easy for all of us to apply according to the indications, and which should be fertile in good results, judging from what has already been seen."

THOMAS LINN, M.D.

PARIS, May 9, 1887.

PROCEEDINGS OF SOCIETIES.

AMERICAN SURGICAL ASSOCIATION.

THE Eighth Annual Meeting of the American Surgical Association was held May 11 to 14, inclusive, in the reading-room of the Army Medical Museum, Washington, D.C.

The Association was called to order at 11 A.M. on the 11th instant by the President, Dr. Hunter McGuire, of Richmond, Virginia, who delivered the President's Address, taking for his subject

THE NEED AND VALUE OF CO-OPERATIVE WORK IN SURGERY.

He spoke of the necessity and advantage of co-operative work, and afterwards suggested several changes in the management of the meetings of this Association. The day has

passed when the dictum of one man, no matter how exalted he may be, is received without question. Disease presents problems peculiarly difficult of solution, for we cannot apply to the human machine the fixed rules by which inanimate bodies are governed. The result of work in private houses and in public hospitals must be different. Besides this, it is necessary to get rid of the rubbish with which current literature is flooded by ignorant but ambitious contributors. This becomes a comparatively easy task, however, when we are confronted with the problem of knowing when to reject material presented by skillful but unscrupulous workers, who to gratify their own personal vanity make false returns of their labors.

In concluding his address the President made the following suggestions:

1. The appointment annually of a business committee to prepare the work of the Association. Two general subjects in surgery should be selected to be discussed at the morning sessions of the first and second days of each meeting.

2. The address of the President and other papers should be limited to half an hour, and those who take part in the discussions to fifteen minutes.

3. The abrogation of Article IX. of the Constitution will allow us to admit to Fellowship some men in this country who are really needed in the Association. Although believing in the rigid observance of the Code of Ethics of the American Medical Association, and the absolute necessity of its enforcement in that body, there is no need for it in our Association. The only code that we should have is scientific work.

4. The report of the committee with reference to the American Congress of Physicians and Surgeons should be adopted.

5. The constitution should be so amended that propositions for membership shall lie over for one year. The qualifications for Fellowship should be age, experience in surgical work, scientific attainments, with general culture.

A committee was appointed to take into consideration the suggestions offered by the President (Drs. S. W. Gross, C. H. Martin, D. W. Yandell, Moses Gunn, and C. Johnston).

The Association then went into Executive Session with closed doors.

Afternoon Session.

F. S. Dennis, M.D., of New York City, read a paper on

THE EXPLORATION OF THE BLADDER BY THE SUPRA-PUBIC METHOD.

The supra-pubic operation of to-day is practically the same as the old operation: the only change has been an improvement in *technique*. The first reported operation was

that of Franco, in 1561. From that period to 1879 cases were not numerous, but from 1879 to the present time the operation has been done with such success as to attract attention throughout the world. The time is not far distant when practically the only two operations for vesical calculus will be supra-pubic lithotomy and litholapaxy. Supra-pubic lithotomy is simple in *technique*, safe in execution, free from injury to the reproductive organs, radical in results, curative in application, and brilliant in statistics. The many serious accidents attending the lateral operation are entirely avoided.

Technique of Operation.—For a few days before operation a milk diet should be employed. The day previous to operation the bowels should be moved with castor oil, and on the morning of the operation an enema should be used so as to empty the rectum for the introduction of the rubber bag, and the abdomen should be washed with an antiseptic solution. After the patient has been etherized, the surgeon should introduce a rubber bag into the rectum, above the internal sphincter, into which twelve ounces of warm water are to be introduced. This quantity will have to be increased or diminished according to circumstances. The danger of rupture of the rectum in elderly people and in young boys should be borne in mind. The urine should be withdrawn, and six ounces, more or less, of an antiseptic solution introduced into the bladder. The catheter may be left in the bladder and stopped with cork, and this will serve as a guide to cut upon. The distention of the rectum and bladder increases the distance from the pubes to the anterior cul-de-sac of the peritoneum to three inches. The incision should be made in the median line, and should extend for three or four inches above the pubes. When the transversalis fascia is reached, the use of retractors (on the principle of the eye-speculum) facilitates the operation. Having divided the fascia, the end of the catheter can be felt and cut upon as a guide. The bladder may then be seized with two tenacula and opened. Where free exploration is desired, sutures are introduced on each side of the incision. The stone is removed either with the fingers or forceps. The bladder may then be washed out. A catheter should be introduced through the urethra, but not left longer than twenty-four hours, on account of the danger of exciting traumatic urethritis. In most instances the wound of the bladder should be left open. In cases of calculi the condition of the vesical tissues is such that primary union is unlikely. In certain other conditions, such as rupture, the wound may be closed, for here the condition is different. The abdominal opening is to be closed and a tube introduced.

The operation is indicated (1) for hard, large calculi, and in persons suffering with paraplegia and deformities rendering lateral

lithotomy difficult; (2) for removal of certain foreign bodies, such as hair-pins, etc., or for the treatment of chronic cystitis; (3) in cases of tight stricture, fibroma of prostate, tumors of the bladder; and (4) for rupture. In its extraordinary simplicity, its reduced mortality, its freedom from danger, and its safety for the general practitioner, it compares well with litholapaxy.

The speaker had collected one hundred and twenty-four cases of supra-pubic operation for stone done since 1879. Previous to this date the rate of mortality was thirty per cent. Since then the mortality has been reduced, there being eighteen deaths, a mortality of fourteen per cent. Seven of these deaths may be justly excluded, giving a mortality of nine per cent. According to Sir Henry Thompson's statistics, the death-rate from the lateral operation is twelve per cent.; according to the same authority, the mortality of lithotomy is six per cent. In considering the mortality of this operation, two facts are to be considered. The mortality may be improved by more rigid antiseptic precautions. The second fact is that the operation has been limited to the largest stones. When the smaller stones are included the death-rate will be reduced.

Specimens and models showing the position of the bladder under various conditions were then shown.

John H. Packard, M.D., of Philadelphia, presented a paper on

SUPRA-PUBIC CYSTOTOMY FOR OTHER PURPOSES THAN THE REMOVAL OF CALCULI.

The history of the operation as it appears in cases recorded from 1750 to 1886 was briefly discussed, and the opinions of authors in regard to the hypogastric operation in general, and especially with reference to the evacuation of urine, were next given. In regard to the anatomical relations of the peritoneum to the bladder and abdominal walls, much diversity of opinion was found to exist.

In 1883 the speaker had removed by supra-pubic cystotomy a piece of shawl-pin five inches in length, which had been passed through the urethra. Since then he has done this operation a number of times. In cases of retention of urine from stricture, where a fair attempt to pass an instrument fails, he draws the urine by aspiration. In a short time subsequently an instrument can usually be passed. He did not recall a case in which it was necessary to repeat aspiration.

The following cases were cited:

July 7, 1855. Mr. G., 85 years old, had retention due to enlarged prostate. The bladder was greatly distended. The urine was drawn off with a long catheter; but, as he desired more permanent relief, supra-pubic cystotomy was performed, and a glass ovariectomy tube bent like a tracheotomy tube was introduced. The patient improved decidedly, but suddenly

died July 9, from heart-failure the result of sudden exertion.

J. C., aged 43, came under observation January 21, 1885, at the Pennsylvania Hospital, with a history of retention the result of old stricture. The bladder was greatly distended, and no instrument could be passed. There were frequent chills and profuse sweats. The next day Dr. Thomas G. Morton made a perineal incision, opening an abscess; the catheter then passed into the bladder. The following day the bladder was again distended. Supra-pubic incision was then done. A catheter passed through the abdominal opening, and the neck of the bladder came through the perineal wound. On February 7 a large mass of slough came from the abdominal wound. The patient then rapidly improved, and was discharged cured April 21.

H. F., 43 years old, had retention for four days. The penis, scrotum, and skin of abdomen were swollen, tense, and rigid. Free incisions were made: the bladder was opened and a tube introduced. On June 4 an instrument was passed by urethra; on July 13 the patient was discharged, and has continued well.

Mrs. S., aged 63, admitted with enlarged prostate and frequent attacks of retention. August 13, 1886, supra-pubic incision was performed and the bladder opened. Although the condition was improved, the patient died of exhaustion August 29.

The next two cases occurred at the Pennsylvania Hospital within the past few weeks.

W. E., aged 70, was admitted April 24, 1887, with retention due to enlarged prostate. Supra-pubic cystotomy was performed and a large quantity of putrescent urine removed. A rubber tube was passed into the bladder. The urine contained albumen to the amount of one-half its bulk; granular casts were also found. A typhoid condition developed, and the patient died on the fourteenth day after admission.

R. W., aged 40, was admitted the same day. He had double inguinal hernia and double hydrocele. He had passed no urine for fourteen hours. Catheterization was attempted without success. Supra-pubic incision was then performed, and a rubber tube introduced. He has done well since then, and is beginning to pass some water by the urethra.

Concerning the method of procedure, the fullest antiseptic precautions should be observed in these cases. In most of the cases on which the author had operated, the question whether or not the bladder should be distended had not presented itself, as the bladder was already over-distended. The bladder should never be more than moderately distended, not more than six or eight ounces of a boric-acid solution being employed. To retain the water in the bladder, a convenient method is to bend the urethra on itself and hold it in this position. There

seems to be more advantage and less risk from the distention of the rectum. Many writers recommend that the bladder be steadied by an assistant; but this was regarded as needless and objectionable.

The incision through the skin should be free enough to give ready access to the deeper parts. When the bladder is reached, it is desirable to secure it in some manner before puncturing; for this purpose a small double hook may be used. A small tenaculum may answer. When a large opening is to be made, a double ligature is perhaps the best device. In cases of retention, the curved trocar and canula may now be at once used. The canula should afterwards be substituted by the tube. The speaker's custom is to make the opening in the bladder just large enough for the tube. The proper point for making the opening seems to be about at the middle of the exposed portion of the wall of the bladder, which would be about one inch or one and one-half inches above the pubes.

The drainage-tube should go well into the bladder, and have lateral openings only near its extremity. The external end may be closed with a cork or clip or by bending it. In old men with atonied bladders he had sometimes used glass tubes. If a large opening has been made in the bladder, it may be closed around the tube with a few catgut sutures. The tendency of the wound is to close quickly, except where the tissues as well as the general system are in bad condition. The edges of the wound in the skin can be apposed with sutures of catgut or silkworm-gut.

In concluding, the speaker asked, "If the supra-pubic section had been first tried and generally adopted, is it likely that the perineal operation would have been afterwards performed, on account of its greater ease, simplicity, and efficiency?"

The next paper,

TO WHAT EXTENT CAN WE CLASSIFY VESICAL CALCULI FOR OPERATION? WITH A REPORT OF CASES AND REMARKS ON THE DIFFERENT METHODS EMPLOYED,

was read by A. Vanderveer, M.D., of Albany, New York, who communicated the detailed histories of forty-one cases upon which he had operated. The various methods employed were lithotomy, rapid dilatation of the urethra, and Bigelow's operation (litholapaxy). Among them there were seven cases of perineal lithotomies, with two deaths (of very old men with large calculi) and five recoveries. Of attempted litholapaxies and an immediate perineal lithotomy there were two cases, both resulting in death,—one occurring in the speaker's practice, the other in the practice of a friend. Both were large stones, the patients presenting a history of much suffering through many years. Of dilatation of the urethra in the female and washing out of

fragments or removal of stone entire there were six cases, all recovering with no complication whatever. Of urethral calculi in the male there were four cases, all recovering. Of simple lithotripsy in the male there was one case, followed by recovery.

Of litholapaxies attempted but not completed there were four cases, three ending in death, and one (the stone hiding in a sac) later underwent perineal lithotomy and recovered. One was probably complicated with some form of tumor of the bladder and a history of chronic disease of the kidneys. One was a case of chronic alcoholism, one was complicated with sacculated bladder, and the last two were cases of surgical kidney of the gravest character.

Of the litholapaxies in the male there were eighteen patients, having twenty-two operations, four requiring a second operation. Of the number sixteen recovered and two died; of the latter, one after the first and one after the second operation.

With reference to supra-pubic lithotomy, the author said that the operation must necessarily deal with severe cases of large, and in some instances sacculated, stone. He did not believe that we should ever expect from it as great a percentage of recoveries as from rapid lithotripsy. A table of reported cases of supra-pubic operations was given, showing in one hundred and forty-two adult cases a mortality of twenty-two per cent.; in children under fifteen years of age, one hundred and thirteen cases gave a mortality of 10.5 per cent.

The operation of litholapaxy is certainly indicated where the stone is small or of moderate size. Contrary to the teachings of a few years since, this can be done in very young male children with proper instruments. In male adults, if there is severe chronic cystitis, no matter what is the size of the stone, the supra-pubic or some form of perineal lithotomy seems best. The cystitis can then be successfully treated, and there is less danger of a recurrence. The speaker thought that it would be found by future statistics that cystitis has much to do with the necessity for a second or third operation. He thought that the condition of contracted bladder in the male with adhesions had not received the attention which it demanded. This must in some instances embarrass supra-pubic lithotomy. On anatomical grounds, the supra-pubic operation will be much simpler in the youth, as the bladder is much higher in the pelvis at this time of life. In girls rapid dilatation or supra-pubic lithotomy will undoubtedly reach all cases. In adult women vaginal lithotomy may be added.

The discussion of these papers was postponed until Thursday morning.

Adjourned.

(To be continued.)

OBSTETRICAL SOCIETY OF PHILADELPHIA.

MEETING OF APRIL 7, 1887.

(Continued from page 550.)

LABOR COMPLICATED BY LARGE HARD HEADS.

DR. M. PRICE was called to this patient three weeks before her delivery. She informed him that she was in labor, and that her time had expired. Examination showed the cervix but little dilated, the os not being larger than a silver quarter. There was quite a discharge from the vagina. The pains were at short intervals, and were unquestionably labor-pains. The woman was in good condition, and he had no doubt that labor would go on. He left, giving instructions to send for him if the pains increased, and that if not sent for he would call next day. He had attended this woman in two previous pregnancies, both children being large and the labors tedious: so he anticipated that this one would be a slow labor. The next day the pains were less than on the previous day, and there was no change in the cervix. He did not hear again from her for three weeks, when the husband called and stated that his wife had been in labor all night and all day. He now found the cervix wide open, but the presenting part of the child so high up that he was not able to say what part was presenting. Passing the entire hand into the vagina, he found a vertex second, but the head would not engage. After waiting two hours, he found the head had been pushed to the side of the pelvic inlet, with the occiput resting on one side and the neck and shoulders on the other, and determined to ascertain the difficulty. He pushed his hand up into the womb, and had no difficulty in bringing the head back to its first position, but found that it was completely ossified. There was no pulsation in the cord that he could detect, and he at once decided to deliver by turning, as he thought he could deliver the child in that way sooner than in any other. He at once secured the feet, and soon had the body and arms delivered. The forceps were applied to the after-coming head, and it was delivered after quite a pull at the superior strait, but with ease through the soft parts without the instruments. There was no injury to the mother, and she made a rapid recovery. The child was still-born. Its head measured sixteen inches in occipito-frontal circumference. There can be no doubt that the mother's pelvis is much above the average size, as a head perfectly ossified could not have passed through a pelvis of less than sixteen and one-half inches, as the soft parts would take up at least one-half inch. Standard authorities give the circumference of the female pelvis at the inlet at from thirteen to thirteen and one-half inches.

ABDOMINAL SECTIONS.

DR. JOSEPH PRICE: In reporting a mixed group of cases treated by these methods, of

which Dr. Tait has been the first and chief advocate, I desire to make brief reference to Dr. T. Gaillard Thomas's article on "Laparotomy as a Diagnostic Resource," published in the *Medical News*, Philadelphia, December 11, 1886. Therein Dr. Thomas expresses in full Mr. Tait's views. They are simply, without the mention of Mr. Tait's name, an embodiment of the views given vent to by Mr. Tait while on a visit in America in the autumn of 1884. Dr. Thomas would select the text of Mr. Tait's law, his own axiom, as a motto for the walls of a hospital devoted to abdominal surgery: "When a doubt as to the diagnosis of an abdominal neoplasm of serious character or of certain obscure pathological conditions of the abdominal cavity which threaten life exists, give the patient the benefit of explorative incision." Mr. Tait, in like clean and terse English, expressed the same view in a clinical lecture at the Hospital of the Jefferson Medical College, September 15, 1884, when he said, "My experience teaches me that it is a surgical crime to allow a patient to go to her grave without operation where it offers a possibility of relief."

Dr. Thomas, with great frankness, reports five cases as examples of the class in which he had to regret non-interference on his part: cases in which "we" or "I" decided against operation. The patients died. Further he says, "I regret to say that I could more than double the number of cases illustrating this part of my paper. Few such cases occur to me now, for the very reason that I am a strong advocate for explorative incision as a diagnostic resource."

As to another class of cases in which Dr. Thomas meets with happy results, he reports as follows: "There is a class of cases in which in my hands explorative incision has yielded such brilliant results that I shall devote full consideration to it. I allude to cases of ascites in the female."

Mr. Tait, in the address I have referred to, gave as an example in point a case operated upon four years previous. "The patient, a young lady, had an enormously enlarged abdomen, due to ascites,—a fact I had recognized. I opened it by incision for exploration and drainage: by this means the fluid is evacuated just as well as with the trocar; but you cannot feel anything with a trocar; but with a clean cut of two or three inches you can introduce one or two fingers and find out the actual condition of the pelvic organs as you can in no other way."

The pioneer work done by Mr. Tait, his influence in exploratory work and treatment of diseased conditions of the tubes, is referred to by Mr. Greig Smith in a very fair and generous spirit. "Tait's name is mainly connected with inflammatory diseases of the tubes, and his influence has been strongly felt in the substitution of operation for actual disease as against vague nerve-symptoms."

I am strongly of the opinion that an incision which admits only two fingers and not the whole hand is a sufficient incision. Dependence upon fingers skilled in manipulation will serve best and effectively guard against danger in any pelvic operation. Herein I differ from Dr. Thomas, who urges, "Make an incision which will admit the whole hand: one which will admit two fingers only is hardly warrantable." There is great danger in multitude of fingers of irritating the bowels with the hand, and further running great risk by exposure.

Many fatal results attend men beginning the study and practice of surgery of the abdomen. This is illustrated by the statement of an abdominal surgeon: "I do not count my first thirteen cases, because I was learning how to do it." In this there was considerable Rip Van Winkle arithmetic: "We won't count this one." The present good results in the hands of young surgeons must not be attributed to the taking advantage of all the so-called "latest antiseptic improvements." In this relation I will make brief allusion to an experience with well-trained young surgeons, six in number, doing nine pelvic operations due to inflammatory trouble, suppurating, adherent, and matted together pelvic viscera. The operations were all completed with but one death, notwithstanding they were all bad cases.

In illustration, I present a specimen of

PYOSALPINX,

removed by Dr. Thomas G. Morton. This patient had an enormously-enlarged abdomen. She had been seen by a prominent gynecologist, who had plainly stated that there was no ovarian trouble, and recommended tapping, which was done. It is my impression that by the first tapping the large cyst was ruptured; the dropsical accumulation followed. Dr. Morton found upon examination, after repeating the tapping (the patient refusing any other operation), a small tumor or collapsed cyst. He refused to repeat the tapping, and urged section. He kindly asked me to see the patient. Upon examination, I was fully satisfied of the correctness of Dr. Morton's diagnosis, and agreed with him in urging section. It was immediately done. Extensive adhesions had developed from the tapplings; free hemorrhage followed. He removed a large collapsed cyst, and by irrigation large quantities of old clot. An interesting feature of the case was the existence of two pedicles, the pelvic and a fan-shaped one over the diaphragm and stomach. The case presented very interesting and instructive features. Result, cure.

PYOSALPINX.

The next case, Mrs. D., white, æt. 18 years, on October 31, 1883, presented herself at the Philadelphia Dispensary, complaining of at-

tacks of free bleeding and of pain in the left groin and left submammary region, intensified by locomotion. On examination, the uterus was found low down and retroverted; the left ovary was tender. On June 16, 1885, vulvo-vaginal gland enlarged and tender; abscess incised and packed. On July 1, 1885, she complained of pain in the back, left shoulder, and left inguinal region. She was put on general treatment. Menstruation was normal. November 9, 1885, examination showed the uterus retroverted and the ovaries tender; vulvo-vaginal glands enlarged; abscess incised and packed. November 25, 1885, the uterus had been treated for its displacement, and at this time was found in good position; both ovaries were enlarged and tender; the right ovary was the largest, the left the most tender. February 24, 1886, uterus drawn slightly to left. May 24, 1886, complained of pain on coition. January 25, 1887, pain in right inguinal region. On examination there were found tortuous, cystic, boggy masses filling up the whole right side of the pelvis.

January 26, 1887, Dr. Price opened the abdomen in the median line, the incision being enlarged to three and a half inches on account of deep adhesions to all of the pelvic viscera. The right tube charged with pus and the right ovary with a parovarian cyst as large as a cricket-ball were removed, the pedicle ligated with silk and dropped. Free irrigation was employed, the wound was closed with silk, and no drainage used.

PYOSALPINX.

(Reported for J. S. K. MORTON, M.D.) Mrs. T., white, æt. 36, complains of pain in right iliac region and extending down the right thigh, increased by locomotion. General condition bad; dissipated.

Examination.—Uterus in good position; to right of cervix is a firm, pedunculated tumor, filling up the pelvic cavity on that side, firm, nodular, and adherent.

Operation, January 25, 1887.—A two-inch incision was made two inches above the pubis; two fingers were introduced, and everything found practically normal except the right ovary and Fallopian tube. The ovary was as large as a pigeon's egg, and firmly bound down in every direction, and apparently more cystic than normal. The tube was likewise bound down, extremely thickened, and contained fluid. After carefully examining all around the adherent mass, a point more friable than the other adhesions was found and torn up. This done, the enucleation became a matter of patience and application of judicious force until the whole mass had been shelled from its inflammatory bed. When thus freed, the ovary and tube were brought out of the wound and the pedicle doubly ligated as near the uterine cornu as possible, and divided with scissors. Previ-

ous to dropping back the pedicle, the remainder of the Fallopian canal in it was thoroughly swabbed out with strong bichloride solution, eighteen grains to the ounce. Scarcely any oozing took place, and after thoroughly irrigating with water that had been boiled and carefully sponging, the peritoneal cavity was found to be perfectly dry. The incision was closed without a drain. Time, fifty-five minutes.

Progress.—Occasional slight nausea was the only untoward symptom following the operation; evening temperature, 99.4°; next morning, 100°. After that it did not rise until the evening of the fourth day, when it mounted to 102°, and she complained of considerable abdominal pain, with much vomiting. This set-back had come on as a result of getting up and walking about the room some hours before, during the absence of her nurse. The fifth day found her with marked symptoms of peritonitis, vomiting, and towards evening shock and evidently dying. Death occurred during the night.

Post-Mortem.—Parietal wound in good condition; about half a pint of cloudy serous fluid in the peritoneal cavity; abdominal contents matted everywhere with very recent lymph; no blood or clots; kidneys somewhat granular, but not nearly so much so as might have been expected from her dissipated manner of living; other organs practically normal.

(To be continued.)

PHILADELPHIA ACADEMY OF SURGERY.

A STATED meeting of the Philadelphia Academy of Surgery was held May 2, 1887. In the absence of the President, Dr. S. W. Gross occupied the chair.

Dr. F. H. Gross exhibited a

TUMOR OF THE ABDOMINAL WALLS,

and made the following remarks:

"I have here a tumor which I removed at the German Hospital three days ago. It was more interesting before removal than it is now, on account of its situation. The patient was a woman, aged 46 years, married, who had twelve children, eight of whom are living; the other four died in infancy or early childhood. The patient was a large, healthy-looking German, weighing one hundred and forty-five pounds. She first noticed this growth in the abdominal walls about twenty years ago, at which time it was no larger than a pea. It was situated about two and one-half inches above the umbilicus, and a little to the right of that point. The tumor grew very slowly, and two years ago had only reached the size of a walnut. It remained of this size until three months ago, when it rapidly increased to its present dimensions, about those of a small fist. Within the past two months there appeared shooting and darting pains extending around the abdomen; previous to

this there was no pain connected with the tumor.

"The deep attachments of the growth were very deceptive. Those who examined it believed that it was attached to the peritoneum, and at the operation we were prepared to remove it, even if it extended so deep. At the operation, however, it was found external to the sheath of the rectus muscle. It appears to be a fibrous growth which is undergoing myxomatous degeneration."

Dr. F. H. Gross also exhibited the growths from a case of

MULTIPLE LYMPHOMATA OF THE AXILLA.

"The patient from whom these growths were removed was aged 43 years, the wife of a clergyman in the interior of the State. She is the mother of eight children, all living. Her parents also are living. She first noticed a swelling in the right axilla about the middle of December, 1886, seventeen months ago. At this time there appeared to be two growths the size of a walnut. They gradually increased in size until they gave rise to considerable inconvenience on account of their bulk. There was no pain. She desired to have them removed. I expressed the opinion that they were lymphomata. There were also two growths above the clavicle not larger than hazel-nuts.

"I made a straight incision in the axilla on the thoracic side and removed two dozen of these glands, the largest being the size of a goose's egg. It is remarkable that the glands above the clavicle, which I had expected to remove by a later operation, have almost entirely disappeared. The operation was done eleven days ago, and the glands are now not larger than a small bean. There is no taint in the family. I think that the origin of the tumors must have been due to indifferent causes.

"I had a similar case a year or two ago, in which the patient subsequently died of phthisis. The wound did not heal, and there was a continual discharge from it. In this case there is no tubercle."

Dr. S. W. Gross: "My own experience is that, independently of Hodgkin's disease, multiple lymphomata such as we meet with in the neck, and which are so easily enucleated, are exceedingly uncommon in the axilla. The majority of tumors of the axilla connected with the lymphatic glands that I have operated on have been tubercular glands undergoing cheesy degeneration and lympho-sarcoma. I have yet to see a case like this, and I have seen a good many cases of tumor of the axilla. At my first clinic in January this year I had a case of lympho-sarcoma of the axilla, and I remarked to the class that lymphoma, of which I had shown a good many cases situated in the neck, I had never seen in the axilla. Drs. Senn and Cheadle, who were present, agreed with me."

MEDICAL SOCIETY OF THE COUNTY OF
NEW YORK.

A STATED meeting was held April 25, 1887, the President, LAURENCE JOHNSON, M.D., in the chair.

EXTERNAL URETHROTOMY—A PLEA FOR ITS
PERFORMANCE IN MINOR TRAUMATISMS
OF THE URETHRA.

Dr. L. BOLTON BANGS read a paper with this title. The first proposition offered for discussion was that the operation should be resorted to earlier than it usually is. He had become convinced from the observation of cases in the hospital that their condition was rendered infinitely worse by the passage of time, when the deeper urethra became fixed in a semi-cartilaginous mass which a subsequent operation could never properly overcome. The early operation should be performed for acute traumatism: after falls astride wagon-wheels and other objects; after kicks and blows on the perineum; after penetration of the perineum and wound of the urethra by sticks, etc. The urethra being damaged to a greater or less extent after these injuries, the process of repair sets in at once, but to be interrupted or interfered with periodically by the necessity for the urethra to perform its function. The bladder expels its contents sometimes with great violence, and thus irritation is set up, which finally results in inflammation and the formation of cicatricial tissue in and around the urethra.

Not only should external urethrotomy be resorted to at once after known injury of the urethra and extravasation of urine or inability to pass the catheter, but there are also cases in which the only evidence of injury of the urethra might consist in the escape of a few drops of blood from the meatus. An instrument of large or fair size may pass easily into the bladder, yet experience shows that subsequent trouble will be avoided only by this operation. The slight injury to the urethra might result in a follicular inflammation; a little pus-cavity forms; the urine passing over the urethra makes this condition worse; and there may finally develop extravasation and cicatricial tissue. The object of external urethrotomy is to obtain rest for the urethra and prevent liability to extravasation and its subsequent unfortunate results. The operation should be performed as early as possible, and the first physician who is called to the case, if possessed of a slight amount of manual skill, and having with him a guide and a scalpel, would be able to perform it without difficulty. The operation also should be resorted to when opening a perineal abscess in a patient with a stricture of large calibre, for it is not sufficient to evacuate the abscess and perform catheterism; the urethra should be divided in order to prevent the development of more deplorable results.

The second proposition upon which the

author invited discussion was that external urethrotomy is comparatively devoid of danger, although not absolutely so, as this could not be said of any operation on the human body. Its dangers, as well as its difficulties, had been overstated. On looking over hospital records he had found that deaths following the operation had occurred in patients with preceding kidney-disease, probably arising from the urethral disorder or other devitalizing disease, and were not due to the external urethrotomy.

DISCUSSION.

Dr. F. N. ORIS fully coincided with Dr. Bangs with regard to the probable benefit to be obtained by early operation in cases of external injury of the urethra. Our most difficult and refractory cases of urethral trouble are those of traumatic origin. The resultant stricture is often so extensive that it cannot be fully divided, and will return. To illustrate the importance of an early operation, he referred to a case in an English hospital, that of a patient who had a perineal swelling, and the surgeon, taking it for a difficulty outside the urethra, independent of extravasation, applied a poultice to prepare the abscess for the knife. But by the next day extravasation had taken place, and the patient died. He thought the operation was a safe one.

Dr. E. L. KEYES could not take exception to any of the statements made by the author of the paper. He thought the operation of external urethrotomy should be performed early after injuries of the urethra, and also in cases of stricture of the deep portion of the urethra calling for either divulsion or division. The operation he regarded as simple, although when a guide could not be introduced it was attended with some difficulty.

Dr. Keyes further said that the former custom of dilating deep urethral strictures is falling gradually into disrepute. If the tissues were not tight, if the stricture was not resisting, the patient might get along without suffering special inconvenience by passing a moderate sound; but when the stricture was tight, the patient was liable at any time, by passing sounds of increasing size, to get up a urethral chill, an inflamed testicle, and all sorts of complications. Such accidents were not likely to occur if the deep urethra were divided by external urethrotomy. The operation of divulsion in such cases had pretty much fallen into disuse, and internal urethrotomy in his experience was disastrous. If he himself had a deep urethral stricture, he would vastly prefer to have it cut externally to having it divulsed or cut internally to a sufficient extent.

Dr. CHARLES MCBURNEY was glad to hear ideas which were gradually and surely gaining the approval of surgeons expressed so clearly by Dr. Bangs. He thought external

urethrotomy for traumatism of any moment was a highly proper procedure. It was proper because it was the only means of avoiding dangers which were immediate and also remote. Regarding the operation itself, he thought something might be said which would tend to lessen the fears of the patient and those of physicians not accustomed to perform it regarding its severity. The object of the operation was only to provide for perfect drainage of the urine and products of inflammation. It was not done for the purpose of dividing the stricture. There might be a stricture three or four inches in length in the deep urethra, but it was not necessary to try to divide it when performing external urethrotomy. The latter operation was performed for the purpose of drainage, and a small opening was sufficient. The stricture could be divided by internal urethrotomy. External urethrotomy need not involve a single important structure; hemorrhage could be controlled without any danger. If these facts were borne in mind, he thought the operation would lose some of its terrors.

He (Dr. McBurney) thought there were some cases of slight traumatism of the urethra which did not call for external urethrotomy, but they were very difficult to define. He might say, however, that in a case of injury to the perineum in which there was no evidence of laceration of the urethra other than perhaps the escape of a few drops of blood, in which there was no tumefaction of the urethra, in which it was perfectly easy to pass a large instrument, and in which there were no crevices to engage a small instrument, in such a case he would not do external urethrotomy. But he would wash out the bladder after each evacuation.

Dr. BANGS, in closing the discussion, said he was glad to see such uniformity of opinion with regard to the propriety of external urethrotomy in the class of cases under discussion. In further illustration of its importance, he said a man had recently come under his observation who fell upon the table five months ago, striking the perineum, in consequence of which there resulted slight tumefaction and scalding on urination. No blood escaped from the meatus. He was catheterized by the attending physician, and then passed from under his notice. To-day it was difficult to pass a filiform bougie. External urethrotomy would now be performed.

BALDNESS: WHAT CAN WE DO FOR IT?

was the title of a paper read by Dr. G. T. JACKSON. Alopecia prematura alone received attention. Premature baldness, it might be said in a general way, was that occurring before the forty-fifth year, although the period was arbitrary. Subdivisions were made into idiopathic and symptomatic. The idiopathic form began unannounced by any antecedent

disease. Many families had it for generations. The different causes claimed for it were named, but the author gave particular attention to the influence exerted by want of proper care of the hair, as this was under the control of the patient and was a part of prophylaxis and treatment. He was inclined to think that due attention to proper care of the scalp and general hygiene of the body were more reliable than any so-called remedies. Women gave more care to their scalps, and not only was baldness less common among them than among men, but the results of treatment were better. In families in which baldness was hereditary, prophylaxis should commence at birth with proper cleansing of the scalp, the use of soap and water, the brush and comb, and the avoidance of all things which might injure the scalp. The shampoo need not be repeated more than once or twice a week, and, after drying, some unguent, as sweet or olive oil, should be applied.

What not to do was nearly as important as what to do. Pomades, as they were liable to become rancid and injure the scalp, should not be used. Wetting, twisting, pulling, scorching the hair, as fashion demanded, were injurious. Close-fitting hats and caps should not be worn. Anxiety of mind should be combated by cultivating a cheerful disposition.

Baldness due to dandruff, syphilis, typhoid fever, etc., next received attention. In addition to treatment appropriate to the special disease, he again urged the importance of systematic care of the scalp and hair.

DISCUSSION.

Dr. FOX said that when baldness was evidently due to some seborrhoeal condition, to want of cleanliness of the scalp, the shampoo would do a great deal of good. When due to shock or other nervous state, we should have to rely upon hygiene. Then there was a large class of cases which dermatologists had tried to explain in different ways, but he thought their explanations were pretty much on an equality: they did not explain it. He, too, once thought that baldness was due to disappearance of the subcutaneous tissue and tightness of the scalp; but on examining patients he found in many of them the scalp quite movable. Nor did he believe it was due to high hats or compression of the blood-vessels by the head-apparel. In brief, he did not believe baldness in many cases could be accounted for any more than an explanation could be given for the musical talent in some and for the mechanical in others. Patients should reconcile themselves to the homely statement that "what cannot be cured must be endured."

Dr. CARPENTER inquired whether the custom among some physicians of cutting the hair short during or just after an attack of

typhoid fever had any beneficial effect upon the hair.

The PRESIDENT was a firm believer in high stiff hats as a cause of premature baldness, and as a basis for his belief said that baldness was much more common now than twenty years ago.

Dr. FOX doubted whether baldness was more prevalent now than twenty years ago, and Dr. JACKSON said that high hats had been worn by young people in England almost for centuries, yet baldness was not apparently on the increase. He and Dr. FOX both thought no benefit was derived from cutting the hair in typhoid fever.

NEW YORK ACADEMY OF MEDICINE.

A STATED meeting was held April 21, 1887, the President, A. JACOBI, M.D., in the chair.

ON THE PRACTICAL VALUE OF OUR PRESENT METHODS OF TREATING THE UPPER AIR-PASSAGES.

The subject was one referred for discussion to the main body by the Section in Laryngology, of which Dr. B. Robinson was chairman. In the absence of Dr. Robinson, the discussion was opened by a paper by Dr. Francke H. Bosworth.

Dr. BOSWORTH said it is now thirty-three years since Garcia demonstrated the feasibility of examining the interior of the larynx during life, and Czermak, availing himself of Garcia's teachings, presented to the medical profession a new method of treating disease and inaugurated a new specialty. He thought it was highly proper to stop for an instant and take an account of what progress had been made in this specialty. The early days of this specialty were days of instrument-invention, and so rapidly did the number of appliances and ingenious devices for treating diseases accumulate that the impression grew that we treated disease by machinery. Nor was this impression ill founded. Dr. Bosworth thought that when we knew little about the treatment of these diseases our machinery was very extensive. As our knowledge increased the machinery disappeared, until now all of it might be carried in a hand-satchel.

He then spoke of special methods of topical applications in the treatment of the larynx, lower pharynx, vault of the pharynx, and nasal passages. Although speaking of the treatment of these separately, his conclusions with regard to each were the same: namely, that so-called chronic catarrhal inflammation of the larynx, lower pharynx, and vault of the pharynx was due to disease of the nasal passages; that chronic nasal catarrh was due to nasal obstruction, and the only radical means of relief consisted in re-

moving such obstruction. This was to be accomplished by the use of the knife, saw, snare, or cautery. It was true the spray and the douche had their uses, but in no case had they ever cured chronic laryngitis or so-called chronic pharyngeal catarrh. Their action was only palliative and cleansing. No local applications directly to these parts ever cured such inflammation. It was not claimed for them by anybody that they would cure tumors, syphilis, tuberculosis, or paralysis. He had before said that the lower pharynx was in no sense a part of the air-tract. As he had but recently written on the subject of the surgical treatment of obstructions of the nose, he would now devote most of his remarks to the action of the cautery.

He claimed that the cautery destroyed only the superficial layer of the lining membrane of the obstructed nasal cavity, and that therefore its action in overcoming obstruction was not due to its destruction of tissue, but to its coagulation of the superficial structures, their contraction upon the dilated blood-vessels and hyperæmic tissues, in the manner that a film of collodion acts. This being the case, he claimed that the galvano-cautery was an expensive, especially a cumbersome, apparatus; one which could not be used with delicacy and exactitude; which was not without danger; and consequently its use should be dispensed with and chromic acid substituted. The latter possessed every advantage of the galvano-cautery and platinum wire, and had not their disadvantages.

With regard to apparatus for making spray, he showed a hand-atomizer with a single rubber bulb, which he claimed was as effective as the most costly air-pump and receiver; and, for examinations, a head-mirror two and a half inches in diameter was as good as the more costly.

Dr. A. H. SMITH continued the discussion with a brief paper, in which he said there was growing scepticism as to our ability to cure all cases of so-called catarrh of the upper air-passages. Then, referring to the benefit to be derived in the treatment of chronic or sub-acute affections of the lining membranes of those passages by the employment of anodynes and disinfectants, especially by weak solutions of carbolic acid, he pointed out the limitations of such benefits. To show that surgical methods were not indicated in all cases or capable alone of curing diseases of the upper air-passages, he quoted the statistics of certain institutions, going to show that out of thirteen hundred and fifty-one cases only twenty-seven per cent. were considered as calling for an operation. It followed that in over seventy per cent. of the cases other treatment than surgical was required. Any person familiar with the subject must have seen patients with chronic nasal catarrh returning month after month, and year after year, to dispensaries and institutions, having

nowhere been able to find complete and radical relief. This was not true alone of the specialty of laryngology and rhinology. The same thing was seen at clinics for diseases of women,—patients returning for months with chronic uterine catarrh, etc. He believed that a change of structure took place; that the vital conditions were altered, and they could not be restored by any measures which we had yet adopted or perhaps would ever discover. In other words, there were certain difficulties and limitations inherent in the case not chargeable to faulty methods of treatment or to want of skill. He had long since ceased to expect, as he had ceased to promise, complete and permanent cures.

Dr. WILLIAM H. THOMSON discussed the subject from the stand-point of the general practitioner. In his opinion, the treatment of chronic diseases of the upper air-passages should be directed chiefly by two principles: first, by taking cognizance of cutaneous nerve associations in the causation and perpetuation of inflammation of the mucous membranes; and, secondly, local disinfection.

Organs which were in symmetrical pairs, such as the hands, feet, ears, and eyes, were so closely associated in vaso-motor relations that the same effect, as far as their circulation was concerned, was produced in both by an impression made on only one member of the pair. Second, there was a close relation between the sensory nerves of the skin and the vaso-motor apparatus of the viscera immediately beneath. Third, there were special relations between the vaso-motor functions of one part of the body and the nerves of sensation in a particular distant part of the body. Wet feet, for instance, might check menstrual flow. This relation also existed between the feet and the larynx, and between the nerves at the nape of the neck and the circulation in the nose.

Unfortunately, we have few vaso-motor tonics. In colds it would be of benefit to apply cold water to the nape of the neck on rising, keeping the hair dry, and to apply cold salt water to the throat. The neck and shoulders should be washed in cold water, dried, and then rubbed with sweet oil. Draughts of air were more harmful than a walk out in the cold air. Exposure of a portion of the surface of the body, especially at night, should be avoided. As to special covering, a thin woollen undergarment should be worn, and over that a perforated buckskin shirt. Buckskin drawers, perforated, might also be worn. He knew of no special clothing so beneficial as this. Chest-protectors, etc., which covered only a part of the surface, were worse than useless.

Speaking of disinfectants and their application in the treatment of diseases of the upper air-passages, he said it was hard to resist the belief, from the evidence already

given, that the product of inflammation, as such, was always the result of infection. As soon as a particular tissue began to lose its normal amount of vitality, the enemy (micrococci) found it out and began its work. A practical deduction was that, as the onset of disease could be prevented only by excluding germs, so all chronic mucous inflammations could be got rid of only by driving out such germs after they had obtained access to the tissues. Two methods were to be adopted: first, strengthen the vitality of the parts; second, apply disinfectants directly to the affected parts. The greatest advance, he thought, would be made in the discovery of disinfectants and how best to use them.

Dr. H. H. CURTIS had deduced the following conclusions from the observation of a thousand cases of disease of the upper air-passages. In all cases of nasal stenosis from deflection of the nasal septum, etc., there was subacute or chronic inflammation of the lining membrane of those passages, this inflammation extending also down to the pharynx, and here giving rise to glandular hypertrophy. This affection of the posterior wall in the faucial cavity was due to mouth-breathing, and disappeared on opening up the nasal cavities. Any treatment directed to this glandular hypertrophy without treatment of the nasal passages was without success. Disease of the ethmoid cells was generally due to hypertrophy of the middle turbinated body and consequent occlusion and prevention of exit of the ethmoidal secretions. The treatment consisted in the application of chromic acid to the thickened middle turbinated body in order to reduce the obstruction and allow free access of air and outlet for the secretions. He employed this escharotic to the exclusion of others, and he would be unwilling to exchange it for all the sponges, sprays, etc. Its use was followed not only by clearing up of the nasal passages, but also, in consequence of this, by disappearance of the granulations referred to, of laryngitis, pharyngitis, huskiness of the voice. The chromic acid should be used carefully, but he had not seen any bad results from it. The sooner the profession ceased to apply strong astringent solutions and nitrate of silver to the upper air-passages, and gave proper attention to restoring the respiratory functions of the nasal passages, the sooner would laryngology be placed on a higher plane and relief given to countless thousands suffering from so-called post-nasal catarrh.

Dr. W. C. JARVIS thought the spray was undoubtedly of great utility when properly employed. Pound-pressure, he said, meant nothing; but the dimensions of the pneumatic tube and the pound-pressure being given, we had everything. Cocaine would act better, more efficiently, and a less amount would be required when used by the spray than by any other method. Another remedy

to be used from the spray was rhigolene, and it was often to be preferred to cocaine, especially where the latter failed to produce anæsthesia. He could not do without the spray for cleansing purposes. The coarse spray possessed nearly all the advantages of the douche. Powders were best applied fine by the compressed-air spray. Iodoform was best tolerated. Chromic acid and nitric acid had their uses. But chromic acid was a treacherous drug. Doubtless it was of benefit in some cases; but it should not be used for the relief of hypertrophy of the lining membrane. It was a specific in its action on papillomatous tissue. Regarding the comparative value of surgical with other methods, he thought the decision had been pretty well settled in favor of the former. Where weeks and months were required to cure by local applications, relief and cure came from a single sitting when the snare, saw, or cautery was used. The apparently increased discharge in nasal catarrh was due to accumulation by obstruction, not to hyper-secretion. He spoke of the value of applications of vaseline or other unguents and agents for cleansing and protective purposes.

AUTOGRAPHS OF DISTINGUISHED PHYSICIANS.

The PRESIDENT, in accepting on behalf of the Academy autograph articles of three distinguished physicians, presented by members, expressed the hope that other members would follow their example. The autographs of distinguished members of the profession of to-day would be just as valuable a hundred years from now as were those now of distinguished physicians of the last century.

NEW YORK PATHOLOGICAL SOCIETY.

A STATED meeting was held April 27, 1887, the President, T. MITCHELL PRUDEN, M.D., in the chair.

ANTHRACOSIS OF THE LUNGS.

Dr. PETERSON presented the lungs of a man, aged 67 years, who had died suddenly in the street. The post-mortem examination showed fatty degeneration of the heart, to which the sudden death was attributed. The liver was fatty. Both kidneys showed signs of senile atrophy. The interest in the case related to the lungs, which were almost black in color, being stained with carbon. The cut surface stained the fingers black when passed over it. In places the lung was composed almost entirely of fibrous tissue and carbonaceous matter, resembling to the touch a cirrhotic liver. In one there was an abscess the size of a hazel-nut. The man had worked during thirty-one years in the cleaning department of a stove-works, in which he was compelled to inhale an atmosphere so filled with carbonaceous matter and fine particles

of sand as to render vision obscure. The large force of men employed in the same room all had some pulmonary difficulty.

RENAL CALCULUS.

Dr. IRA VAN GIESON presented a large white kidney, containing in the sinus a cylindrical calculus five centimetres in length, one cubic millimetre in diameter, sending off two prolongations about one cubic millimetre in length into the calices. There were connective-tissue indentations on the surface of the kidney corresponding to the branches in the calices.

PHOSPHORUS-POISONING.

Dr. VAN GIESON also presented specimens from the body of a man who died four days after drinking water containing phosphorus. At the autopsy there were observed fatty degeneration of the heart and liver; parenchymatous degeneration of the kidneys; swollen and granular changes in the cells and follicles of the stomach, Brunner's glands, and pancreas. The lesions were those usually seen in phosphorus-poisoning, but two points of interest in the case were, first, tubercles found in only one bronchial gland, and not elsewhere in the body, thus bringing us face to face with the first stage of tuberculosis following phosphorus-poisoning; second, the presence of minute hemorrhages in the lymph-channels of some of the cervical glands.

Dr. CARPENTER asked Dr. Van Gieson whether he based his diagnosis of tubercle on the presence of the bacillus tuberculosis. Dr. Van Gieson replied that he had not examined for the bacillus. Dr. Carpenter said he thought the ground assumed by some, that a diagnosis of tubercular tissue should never be made except on the basis of the presence of the tubercle-bacillus, was unjustifiable; that in many cases the anatomical elements alone were sufficient basis for the diagnosis, although the bacillus should be looked for when practicable; but the absence of this was not conclusive evidence that the tissue was not tubercular.

DEATH FROM DIPHTHERIA IN A CASE IN WHICH INTUBATION WAS PERFORMED.

Dr. BROTHERS presented a part of the respiratory organs of a child, aged 19 months, which had, when he first saw it, croupy symptoms, evidence of limited pneumonia, and was becoming cyanotic. O'Dwyre's tube was inserted into the larynx through the glottis, relieving dyspnoea, but the patient died two days later. The autopsy showed no false membrane on the tonsils or pharynx, but there was a false membrane covering the larynx, trachea, and larger bronchi which could not be removed. There was a spot of pneumonic consolidation in both lungs. The case did not speak against the value of intubation of the larynx.

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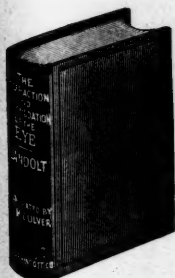
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"Since the publication of Donders's classical treatise by the New Sydenham Society, in 1864, this is the most exhaustive work on the subject of refraction and accommodation that has appeared in the English language, and it is of interest to observe that both are translations. Dr. Landolt, as we all know, is an industrious worker, and nowhere have the results of his close and painstaking study been recorded to better advantage than in the beautifully-printed volume before us. There is no work which the beginner in the study of refraction can read to greater profit than this one of Dr. Landolt's. The author has a happy faculty of simplifying things, and it finds nowhere a more appropriate field for its employment than in the dominion of refraction. Dr. Culver has done his work as a translator well; and we may note as a matter of present interest that he calls the meter-lens a dioptry."—*Archives of Ophthalmology, N.Y.*

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HYPERTROPHY OF THE LEFT VENTRICLE, CIRRHOSIS OF THE LIVER, CHRONIC NEPHRITIS, ETC.

Dr. FRANK FERGUSON presented fresh specimens removed from the body of a man, aged 48 years, who had been a confirmed drinker for eighteen years. His illness dated back three years, but during the last three weeks of life his legs became greatly swollen. There was enlargement of the abdomen and of the scrotum to the size of an adult's head. He had not passed urine for three days prior to admission to the hospital, and the bowels had not moved for five days. He was semicomatose, in which state he died. There was found advanced chronic diffuse nephritis, intense hyperæmia of the kidneys, also of the mucous membrane of the stomach, with thickening of the lining membrane of this organ. There was great hypertrophy of the left ventricle of the heart; the valves were normal; the muscular tissue of the heart was anæmic. The liver was very much advanced in cirrhosis, being composed almost completely of fibrous tissue. There was a great quantity of fat in the scrotum, on the right side there being two large lipomata. The pancreas was unusually firm. The suprarenal capsules had undergone extensive fatty degeneration.

REVIEWS AND BOOK NOTICES.

THE SCIENCE AND ART OF OBSTETRICS. By THEOPHILUS PARVIN, M.D., LL.D., etc. Illustrated with Two Hundred and Fourteen Wood-Cuts and a Colored Plate. Philadelphia, Lea Brothers & Co., 1886. Pp. 701.

This new text-book aims to represent in brief the present state of the science and art of the science for which the author believes "maieutics" (*μαίευσις* and *μαευτήρ*) a more appropriate title than the common one. The work consists of a short introductory and five parts,—viz., Anatomy and Physiology of the Female Sexual Organs, Pregnancy, Labor, the Puerperal State, and Obstetric Operations. The illustrations are numerous, the descriptions clear, the language concise, and the discussion of pathological questions temperate and just. The directions regarding treatment appear sound, but possibly might be made more explicit and positive by one favored with thirty-four years' experience in general practice and a veteran medical teacher. The chapter on Deformities (improperly called Anomalies) of the Pelvis is contributed by Dr. Henry Morris, Demonstrator of Obstetrics in the Jefferson Medical College. As this is not a System of Obstetrics, the interpolation of the work of another interrupts the continuity of the book and implies an incapacity in the author which does not exist. This is not a criti-

cism upon Dr. Morris's contribution, which appears well done, but a plea for the organic unity of a text-book bearing the name of a well-known teacher upon its title-page. As Dr. Parvin is nothing if not classical, we feel that we must notice the use of the word "pubis" in place of "os pubis," while the comparison of the multitude of spermatozoa which, in conception, surround the ovum to the crowd of Penelope's suitors is at least in questionable taste. However, these are trifling criticisms. The author has succeeded in presenting in convenient form for reference the present aspect of obstetrical art, and the work will not only be eagerly sought for by his students, but also will prove acceptable to others who know his studious nature and appreciate his scholarly writings.

A HAND-BOOK OF MATERIA MEDICA, PHARMACY, AND THERAPEUTICS. Including the Physiological Action of Drugs, the Special Therapeutics of Disease, Official and Extemporaneous Pharmacy, and Minute Directions for Prescription-Writing. By SAMUEL O. L. POTTER, M.A., M.D. Philadelphia, P. Blakiston & Co., 1887.

This is the best hand-book on the subject of Materia Medica and Therapeutics for an American medical student with which we are acquainted. In addition to these it has chapters on Pharmacy and Prescription-Writing, and a comprehensive appendix, which contains, among other interesting subjects, Obstetrical Memoranda, the Treatment of Poisoning, and Clinical Examination of the Urine. We think that the departure from the Pharmacopœia in substituting the word "official" for the proper title "official," as applied to approved drugs, is unwarranted. A process might be termed official with perfect propriety, but how can a drug become official? On the contrary, if approved by the Committee of Revision, it can be ordered to be kept in the shops for the use of the profession, and hence becomes properly official.

THE PRINCIPLES AND PRACTICE OF OPERATIVE SURGERY. By STEPHEN SMITH, A.M., M.D. A New and Thoroughly Revised Edition. Illustrated with One Thousand and Five Wood-Cuts. Philadelphia, Lea Brothers & Co., 1887.

Since the first edition of this work appeared in 1879, eight large issues were made without any change being made in the text, although each was designated as an edition. The advances in operative surgery since the work was written necessitated almost complete re-writing of the work from the stand-point of aseptic surgery. A valuable introductory chapter on the principles discusses very appropriately the civil obligations of the surgeon, and due emphasis is laid upon the fact that antisepsis imposes new obligations. "It is of

the utmost concern to every surgeon to become thoroughly familiar with the principles and practice of antiseptic surgery." The book is freely illustrated.

NEW REMEDIES AND CLINICAL NOTES.

EMBOLIC OBSTRUCTION OF THE SUPERIOR MESENTERIC ARTERY.—An interesting case of this is reported by M. Laveran in the *Archives de Médecine et de Pharmacie Militaires* for March. The patient was first thought to have gastritis; then (on account of the severe abdominal pain and vomiting of matters containing blood) acute gastritis due to poisoning or strangulation of the bowel. Cancer came in for a share of the credit, and it was not until the autopsy had been made that the real cause of the trouble was determined.

The patient, æt. 41, entered the hospital on the 29th of October with scarlet fever, and was sent away cured on the 19th of November. The fever had been severe, but had completely subsided by the 4th of November. There had been angina, and the eruption was thoroughly characteristic. On the 14th of January the patient returned to the hospital with excruciating abdominal pains and uncontrollable vomiting. This time there was no fever, the pulse was small and frequent, and there was intense anxiety portrayed in the countenance. The abdomen was excessively painful upon pressure, especially in the epigastric region; slightly tense, but not swollen; constipation for three days; death on the 16th of January. The autopsy revealed a vegetative inflammation of the ascending aorta, the probable source of the embolus, and a sequel of the scarlet fever.

EUCALYPTOL FOR PHTHISIS.—M. Ball, in a communication to the French Academy of Medicine, stated that he had been testing at the Laennec Hospital Dr. Roussel's method of treating pulmonary phthisis by eucalyptol. While his experience was not yet sufficiently extensive to warrant any positive conclusions, it had nevertheless presented him with the most gratifying results. Out of twenty-one cases, ten had been able to leave the hospital and to return to their usual occupations, six had died, and five were still within the wards. Among the latter, one case had ceased to show any bacilli in the matter expectorated six months after the beginning of the treatment, though before that time they were found there in great abundance. Cessation of the night-sweats and of the diarrhœa, and diminution of the expectoration and of the fever, were some of the immediate results of the use of eucalyptol. In one case only did the remedy have to be stopped

during the course of the treatment, and this was on account of some gastric disturbance. Dr. Roussel used for the hypodermic injection one gramme of a fluid consisting of one part of eucalyptol to four parts of pure olive oil. The injections are made in the region of the hip.

TRACHOMA OF THE VULVA.—Under the term "trachoma pudendi," Dr. Tarnowski, of Russia, classifies an affection of the vulva which has for its special characteristics eruption and itching. He sees in it a perfect analogy with the classical trachoma, or chronic granular conjunctivitis. It frequently follows gonorrhœa, a fact which harmonizes well with the well-known notion of the gonorrhœal origin of the ocular trachoma. The skin is roughened, which, according to the microscope, is covered with epithelial papillomata, with the horny layer prominently developed and containing a mass of micro-organisms seated within the epithelium and adenoid tissue. These organisms penetrate deeply into the papillomatous tissue, and are surrounded by a peculiar membrane. The itching is particularly characteristic of this affection, and, instead of scratching, the patients show a tendency to press the parts by pressing the thighs together. The application of cold will cause the itching to cease. Scarification and the use of caustics are the most successful in the treatment of this annoying eruption.

MALARIAL ORCHITIS.—The report of a case of orchitis due to marsh-poison appears in the *Archives de Médecine et de Pharmacie Militaires* for March. The patient, æt. about 23, a soldier of Tunis, suffered an attack of malarial fever two years after the first malarial seizure. On the second day of the fever, which was of the quotidian type, a rapid inflammation began in the right testicle. Under the steady employment of quinine the fever and orchitis had subsided almost entirely by the fifth day, and the patient was well on his way to convalescence. On the ninth day the fever, as well as the orchitis, suddenly broke out again, but this time the latter was on the left side. On the thirty-third day the patient left the hospital cured, with his testicles half their original size and still undergoing progressive atrophy.

THE CAUSATIVE ELEMENT IN UTERINE FIBROMATA.—Again the ubiquitous microbe has come to play, in an entirely new rôle. He has been sought for in almost every nook and cranny of the human frame, and usually some one has been able to find him there, but this time he is met with as the happy occupant and *causa prima* of all uterine fibroids and ovarian cysts, according to a curious and unexpected communication sent to the Société de Biologie by Drs. V. Gallippe and L. Landouzy. They believe that they

have discovered a parasite which by its irritant action upon the tissue-elements causes the growth of these tumors. The experiments of these gentlemen were not sufficiently guarded against every possible source of error, nor were they performed as crucial tests sufficiently upon normal tissues and other tumors in a way to force us to adopt their conclusions as incontrovertible.

PURE DISTILLED WATER FOR TESTS AND HYPODERMIC SOLUTIONS.—M. Lacour recommends passing a current of steam through the worm of the distilling apparatus for about ten minutes before beginning the distillation of water to be used afterwards in delicate tests. In a number of trials without this precaution he invariably found traces of organic matter in the distilled water. The worm of the still when not in use offers most favorable conditions for the development of colonies of many forms of low organized life. This simple precaution has been effectual in reducing to a minimum the organic matter which sometimes finds its way into the distilled water, and which has caused considerable embarrassment sometimes in making exact tests.

CORNEAL ULCERS.—In corneal ulceration, according to Dr. A. E. Prince, of Jacksonville, Illinois, the questions to-day are not whether it is phagedenic, crescentic, rodent, or asthenic, or whether the abscess be hypopyon or not, but we ask, Is it septic? Where is the source of the infection? What is the nature of the micro-organism? and What will destroy it? Empirical methods, which have been most successful, are now explained by their antiseptic effects. The actual cautery, recommended in 1873 by Martinachi, has steadily gained in favor. In 1885, Dr. A. Needen reported his first hundred cases treated by the galvano-cautery without a single failure to arrest the destruction and save the eye. A collyrium of atropine is useful in addition where peripheral perforation exists or is threatened (strength, gr. j-ij to the ounce, preferably in 1000 bichloride solution), or Panas' solution (biniodide of mercury gr. $\frac{1}{4}$, alcohol f3v, water two pints). At the commencement of the treatment the application of a small bag of flaxseed frequently dipped in very hot water is to be recommended for the relief of pain. An ointment of iodoform (two per cent. with vaseline) will be found very grateful, and when the acute stage is past, yellow oxide of mercury (one-half to two per cent.) ointment may be used at night. Constitutional and hygienic measures are also of primary importance. — *Peoria Medical Monthly*.

TETANUS CURED BY HYPODERMIC INJECTIONS OF COCAINE.—The following case came under the observation of Dr. Manuel Lopez (*El Genio Médico-Quirúrgico*):

A laborer, æt. 50 years, of nervous temperament, complained of rheumatic pains and applied for relief. He was ordered to take citrate of magnesia and rubbing, to be followed by oil and a poultice of onions to induce sweating. After one week the condition of the man was very grave. He presented opisthotonos, general rigor, frequent spasmodic attacks, and most painful muscular contractions. His face was pale, and showed evidences of great suffering; his pulse weak, frequent, and irregular; respirations were anxious and short, owing to the inability to expand the chest; intellectual faculties preserved. This was regarded as an idiopathic case of tetanus, owing to the absence of any lesion to which the origin of the disease might be traced.

Chloral was administered, and anodynes applied to the vertebral column and limbs. On the third day he was compelled to suspend the administration of chloral, on account of the difficulty experienced in taking it. In place of this, three injections of five-per-cent. solutions of hydrochlorate of morphine and cocaine in equal parts were made in ten separate places on the body and limbs. Two hours after, the invalid was able to flex the limbs, turn in bed, and open the mouth; the painful contractions had ceased. Continued improvement enabled him, at the end of one week, to return to his occupation. — *La Crónica Médico-Quirúrgica*.

UTERINE HEMORRHAGE.—Hydrastis Canadensis, given in the form of twenty minims of the fluid extract three or four times daily, has been found to check uterine hemorrhage effectively in cases of fibromyomata, subinvolution, and hemorrhagic endometritis, by R. W. Wilcox, M.D., who has also used it in climacteric hemorrhage with success. In many cases it appears to obviate the necessity of recourse to operation. — *New York Medical Journal*.

MISCELLANY.

INTERNATIONAL CONGRESS.—The Committee on Arrangements announce reductions to members of the Congress and their families, as follows: Cunard Line, ten per cent. deduction; Red Star Line, for round trip (Antwerp and New York) tickets, \$100; Inman Line, Liverpool, round trip, \$100; Hamburg Line, \$90; Royal Netherlands, Amsterdam, \$85; North German Lloyd, \$87.50. Important deductions are also made in the rates of Washington hotels.

PROFESSOR GEORGE E. POST, of the Syrian Protestant College, Beyrout, Syria, will attend the International Medical Congress.

DR. WILLIAM GOODALL will remove on June 1 to No. 1418 Spruce Street.

INTERNATIONAL CONGRESS.—Jeffrey A. Marsten, R.A., Deputy Surgeon-General, has been appointed by the Horse Guards to represent the Medical Corps of the British Army at the International Medical Congress at Washington in September next.

The Admiralty has likewise commissioned Deputy Inspector-General Lloyd, R.N., to represent the Medical Department of the British Navy on the same occasion.

THE UNIVERSITY OF PENNSYLVANIA.—On the 2d inst., the Medical Department held its Annual Commencement, graduating one hundred doctors in medicine. Provost William Pepper, M.D., conferred the degrees. The Valedictory Address was delivered by Dr. William Goodell, Professor of Clinical Gynecology. The annual dinner of the Alumni Association was given to one hundred and fifty graduates in the chapel of the University. Dr. R. A. Cleemann presided.

THE Fourth Annual Meeting of the American Climatological Association will be held in Baltimore, Tuesday and Wednesday, May 31 and June 1, 1887, in the hall of the new Physical Laboratory of Johns Hopkins University, Monument Street, near Eutaw.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM MAY 8, 1887, TO MAY 21, 1887.

- LIEUTENANT-COLONEL C. T. ALEXANDER, SURGEON.—Granted leave of absence for four months, with permission to go beyond sea, to take effect May 23, 1887.
- CAPTAIN P. F. HARVEY, ASSISTANT-SURGEON.—Granted leave of absence for four months, with permission to go beyond sea, to take effect June 10, 1887. S. O. 105, A. G. O., May 7, 1887.
- MAJOR MORSE K. TAYLOR, SURGEON.—Retired from active service, May 14, 1887. S. O. 111, A. G. O., May 14, 1887.
- R. H. WHITE.—Promoted to be Surgeon, with the rank of Major, to take effect from May 14, 1887.
- CAPTAIN VICTOR BIART, ASSISTANT-SURGEON.—Ordered for examination by Army Retiring Board at Fort Leavenworth, Kansas. S. O. 107, A. G. O., May 10, 1887.
- CAPTAIN F. W. ELBREV, ASSISTANT-SURGEON.—Ordered for examination by Army Retiring Board at Washington, D.C. S. O. 109, A. G. O., May 12, 1887.
- CAPTAIN JOHN D. HALL, ASSISTANT-SURGEON.—Granted leave of absence for one month, with permission to apply for one month's extension. S. O. 74, Department of Colorado, May 11, 1887.
- WILLIAM N. SUTER.—Appointed Assistant-Surgeon, U.S. Army, with the rank of First-Lieutenant, to rank as such from May 16, 1887.

OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U.S. NAVY FOR THE TWO WEEKS ENDING MAY 21, 1887.

- SURGEON C. U. GRAVATT.—Detached from the U.S.S. "Michigan."
- PASSED ASSISTANT-SURGEON G. P. LUMSDEN.—Ordered to the U.S.S. "Michigan."
- PASSED ASSISTANT-SURGEON RICHARD ASHBIDGE.—Detached from the Naval Academy, and to the Practice-Ship "Constellation."

PASSED ASSISTANT-SURGEON THOMAS H. STREETS.—Promoted to Surgeon.

PASSED ASSISTANT-SURGEON L. W. CURTIS.—Ordered to the "Quinnebaug."

PASSED ASSISTANT-SURGEON J. W. BAKER.—Ordered to the Hospital, Chelsea, Massachusetts.

SURGEON A. F. PRICE.—Ordered to Board duty, Annapolis, Maryland.

SURGEON C. U. GRAVATT.—Detachment from the "Michigan" revoked.

PASSED ASSISTANT-SURGEON G. P. LUMSDEN.—Orders to the "Michigan" revoked.

SURGEON C. A. SIEGFRIED.—Ordered to the "Quinnebaug."

SURGEON R. C. PERSONS.—Detached from the "Saratoga."

SURGEON W. G. FARWELL.—Ordered to the "Saratoga."

SURGEON W. S. DIXON.—Ordered to special duty, Baltimore, Maryland.

SURGEON R. F. ROGERS.—Ordered to the Marine Rendezvous, New York.

PASSED ASSISTANT-SURGEON HOWARD WELLS.—Ordered to the "Jamestown."

SURGEON J. C. WISE.—Detached from the "Jamestown."

SURGEON H. P. HARVEY.—Ordered to the "Iroquois."

SURGEON J. R. WAGGENER.—Detached from the "Iroquois."

DR. S. STUART WHITE (of Frederick, Maryland).—Commissioned Assistant-Surgeon in the Navy, May 19.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U.S. MARINE HOSPITAL SERVICE FOR THE SIX WEEKS ENDING MAY 21, 1887.

- GOLDSBOROUGH, C. B., SURGEON.—Leave of absence extended thirty days, on account of sickness, April 20, 1887.
- DEVAN, S. C., PASSED ASSISTANT-SURGEON.—Granted leave of absence for thirty days, to take effect when relieved, April 12, 1887.
- BRATTON, W. D., ASSISTANT-SURGEON.—To proceed to Port Townsend, Washington Territory, and assume temporary charge of the service, April 21, 1887.
- FESSENDEN, C. S. D., SURGEON.—Detailed as chairman of Board for physical examination of cadets, Revenue Marine Service, May 13, 1887.
- STONER, G. W., SURGEON.—To proceed to Delaware Breakwater as Inspector, and to New York and Philadelphia, to inspect unserviceable property, May 12, 1887.
- IRWIN, FAIRFAX, PASSED ASSISTANT-SURGEON.—Detailed as recorder of Board for physical examination of cadets, Revenue Marine Service, May 13, 1887.
- FATTIE, J. B., ASSISTANT-SURGEON.—Relieved from duty at Baltimore, Maryland; ordered to Marine Hospital, St. Louis, Missouri, May 13, 1887.
- GOLDSBOROUGH, C. B., SURGEON.—Leave of absence extended to June 1, on account of sickness, May 18, 1887.
- GUITERAS, JOHN, PASSED ASSISTANT-SURGEON.—Granted leave of absence for four days, May 21, 1887.
- ARMSTRONG, S. T., PASSED ASSISTANT-SURGEON.—To remain in charge of service at Memphis, Tennessee, until further orders, May 21, 1887.
- DEVAN, S. C., PASSED ASSISTANT-SURGEON.—Leave of absence extended thirty days, May 19, 1887.
- HARRINGTON, P. M., ASSISTANT-SURGEON.—Ordered to U.S. Revenue Steamer "Rush," May 18, 1887.
- NORMAN, SEATON, ASSISTANT-SURGEON.—To proceed to Marine Hospital, Baltimore, Maryland, for temporary duty, May 20, 1887.
- HEATH, F. C., ASSISTANT-SURGEON.—Granted leave of absence for thirty days, May 18, 1887.
- WOODWARD, R. M., ASSISTANT-SURGEON.—Appointed an Assistant-Surgeon May 20, 1887. Assigned to temporary duty at the Marine Hospital, Baltimore, Maryland, May 21, 1887.